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THE MAKING OF A MENTAL PATIENT

THE MAKING OF A MENTAL PATIENT:
AN ETHNOGRAPHIC STUDY OF THE PROCESSES AND CONSEQUENCES
OF INSTITUTIONALIZATION ON PATIENT SELF-IMAGES AND IDENTITIES

BY

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ABSTRACT

This thesis presents an updated study of the social world of the mental patient as he/she subjectively experiences it within a Canadian psychiatric setting. Adopting a symbolic interactionist perspective, specifically a labelling approach to the study of mental illness, this thesis examines the 'moral career' of the mental patient. Objectively, this study focuses on some of the processes by which an individual is segregated, labelled, and subsequently treated as mentally ill. Subjectively, this research examines the manner in which an individual's self-identity is transformed upon hospitalization through various stripping procedures, and how he/she, through institutional processing, is forced to adopt a new definition of self as 'mentally ill'--a social identity that may subsequently lead to the person's stigmatization by society. The findings, in support of previous research, indicated that during the pre-patient phase of their moral careers individuals often undergo experiences which they conceive as alienating and treacherous in nature. Moreover, this study also found that although in-patients are subjected to more 'humane' treatment than in the past, they are still subjected to various institutional procedures which serve to strip the person of his/her former identity and force the person to adopt this new identity of mental patient. Although this study is restricted to the general and exploratory level, it provides a contribution to our under-

standing of the processes and consequences of institutionalization on the self-images and identities of mental patients and toward the formulation of a comprehensive sociological theory of mental illness in general.

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CHAPTER ONE

INTRODUCTION

Who can tell when health ends and disease begins? When disease is found to have shed its blighting influence over the system, is it possible, after establishing the fact, to decide what amount or kind is necessary to occasion aberration of mind, and when this amount or quality is developed? When developed, does it at once manifest its baleful influence upon the brain, by producing insanity; or does it not rather brood over the delicate organ of the mind, and gradually fulfill its dread commission? When again the mind begins to totter, and reason to sit insecurely upon her throne, do the friends and acquaintances of the unhappy sufferer recognize these first monitions? Or do they not rather behold--if indeed they observe any thing--a simple change of habit, slightly perverted moral feelings, or trifling eccentricities of character? (Esquirol, 1845, in Goshen, 1967:316).

The study of insanity has been approached from a variety of perspectives. Traditionally, psychiatrists and psychologists, advocating a medical model stance have conceptualized mental disorders as disease entities located within the individual. Adopting an objective theoretical and nosological classification scheme, such persons have focused on the examination, classification, etiology and treatment of observable pathological behaviour of the patient. In short, in this perspective mental disorders are comprehended from an objective point of view and treated in a manner similar to other illnesses. Man is conceived as a 'diseased' psychological or physio-

logical entity--no attempt is made to understand the world of the mental patient from his/her perspective (e.g. Siegler and Osmond, 1974; Lewis, 1967; and Whybrow, 1972).

In reaction against the premise that mental disorders are intrinsic defects located within the individual, sociologists and social psychologists developed an alternative conceptual framework that places emphasis on the social aspects of mental illness. Conceiving of mental illness as subjectively problematic, proponents of this perspective examine the social processes by which an individual comes to be labelled and treated as mentally ill, and how such a definition impinges upon the actor (e.g. Goffman, 1961; Kutner, 1962; Mechanic, 1962; Sampson, et al., 1955; and Scheff, 1964, 1966, 1967, 1975). The majority of these sociological studies on mental patients were conducted in the 1950's and 1960's. I would argue that institutional life and ideology are not static, but rather dynamic in nature; therefore, it is useful to re-examine the social world of the mental patient as he/she subjectively experiences it in the 1980's. Moreover, these previous studies were conducted primarily in American psychiatric facilities. Up to this point, little research has been conducted on mental patients in Canadian psychiatric institutions.¹

The purpose of this thesis, then, is to present an updated

study of the social world of the mental patient* as he/she subjectively experiences it within a Canadian psychiatric setting. Adopting a symbolic interactionist perspective, specifically a labelling approach to the study of mental illness, this thesis examines the 'moral career'² of the mental patient. Objectively, this study focuses on some of the processes by which an individual is set apart, labelled, and subsequently treated as mentally ill. Subjectively, this study focuses on the manner in which an individual's self-identity is transformed upon hospitalization through various stripping procedures, and how he/she, through institutional processing, is forced to adopt a new definition of self as 'mentally ill'--a social identity that may subsequently lead to his/her stigmatization by society.

The theoretical focus of this research is threefold. First, it examines the pre-patient phase of the mental patient's career--the social conditions upon which an individual is adjudged to be 'mentally ill' and is segregated from the community, and the corresponding reaction of the person so adjudged.

* For the purposes of this study, the term 'mental patient' is defined strictly in the sociological sense. Specifically, this term refers to individuals who possess any of the conditions described in the Canadian Psychiatric Association's Diagnostic and Statistical Manual. In this perspective, the psychiatric conception of mental illness is important only to the extent that this view transforms a person's social fate. Thus, for the purposes of this thesis, anyone who has been admitted into a mental hospital shall be included in the category, 'mental patient.' While one cannot discount that mental patients differ in terms of the type and severity of illness, during the processes of admission, institutionalization, and discharge these individuals undergo similar social experiences. It is these social experiences that are the central focus of the study.

The second theoretical concern of this study is to focus on the in-patient phase in the career of the mental patient. Specifically, this research explores the various admission procedures to which the patient is subjected upon institutionalization, and how such processes serve to strip the individual of his/her present identity. Moreover, this study focuses on the institution's 'privilege system'--the chief context within which the patient is forced to adopt a new definition of self as 'mentally ill.'

Thirdly, this study focuses on the ex-patient phase in the mental patient's career. Specifically, this research examines the problems ex-patients face in attempting to rebuild a more positive identity due to the widespread negative societal attitudes toward individuals of their kind, and the various mechanisms such post-patients develop in order to mitigate the stigma potential of mental illness on their daily round.

As with most research, the present study does suffer from certain limitations. In order to gather data on patient social life, strict statistical measurements or controls were not employed. Rather, descriptive data were gathered on the nature of patient social life through the employment of participant observation and informal interviewing techniques.

Although this thesis is restricted to the general and exploratory level, it provides a contribution to our knowledge concerning the processes and consequences of institutionalization on the self-images and identities of mental patients.

Working from the fundamental premise that self is constituted in the context of social interaction, Chapter Two of this thesis outlines

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the theoretical framework underlying the present research. The basic tenets of the symbolic interactionist perspective and the labelling theory of deviant behaviour are presented as a basis for interpreting the data. Chapter Three presents a review of the existing literature on mental patients, mental institutions and mental illness in general, with specific focus on the four major models of madness and the model adopted for the present research study. Chapter Four discusses the methodological orientation of the study, the research settings and sample employed, followed by a description of the researcher's experiences in gaining accessibility into the settings, and the subsequent data collection experiences with the patients. Chapters Five, Six and Seven present a discussion of the empirical data concerning the three stages in the career of the mental patient. Chapter Eight provides a summary of the findings and discusses the overall implications of the thesis and suggestions for future research.

FOOTNOTES FOR CHAPTER ONE

- 1 Hathaway's (1980) research is one recent notable exception.
- 2 Following Goffman (1961:128), the term 'moral career' shall refer to: "the regular sequence of changes that career entails in the person's self and in his framework of imagery for judging himself and others."

CHAPTER TWO

THEORETICAL ORIENTATION

This chapter serves to introduce the reader to the theoretical framework underlying the present investigation. Specifically, this chapter discusses the following:

- (1) the underlying assumptions of symbolic interactionism;
- (2) the basic concepts of this theory such as, meaning, symbol, mind, role-taking, self, generalized other and society-- concepts which are utilized in the present study;
- (3) the main tenets of labelling theory--a theory of deviant behaviour that is rooted in the Meadian interactionist tradition and has subsequent importance for this research.

The theoretical perspective employed in this research stems primarily from the works of George Herbert Mead.¹ Examination of Meadian theory reveals that it is based on six basic fundamental assumptions:²

1. Man lives in a symbolic world of learned meanings. The objective world with its independent laws has no meaning for man; rather, subjective reality has prime importance for him. For Mead, reality is mediated through symbols.

2. Meanings are derived from symbols which arise in the social process and are universal.
3. Symbols have motivational significance. The definition of the situation aids in determining how an individual will behave. In this sense then, symbols are themselves motives.
4. Mind is a functional, volitional, purposive sensory process which sustains life by serving the organism in response to the environment. Mind emerges out of the social process and is wholly social in character.
5. If the world of objects is mediated through symbols, then other objects can only be experienced in this same way. Self is constructed from meanings that arise in symbolic interaction. That is, self is a linguistic construct that is derived from the social process.
6. Society is a linguistic or symbolic construct that arises out of the social process. (Rose, 1962:3-20).

A fundamental assumption of symbolic interactionism is that humans live in a world of meanings. They respond to objects and events on the basis of the meanings they have attributed to them. For Mead (1934:85), meanings of events are not static or inflexible in nature for if this were the case, social change would be impossible. Neither are the meanings of objects and events merely bestowed upon the individual and learned by habituation. Rather, meanings of events and objects can be changed through the creative acts of individuals and the individual may influence the numerous meanings that form his culture as well as being influenced by these meanings himself. Meanings then, are social products that are formed through the defining activities of people as they interact with one another:

The universe of discourse is constituted by a group of individuals carrying on and participating in a common social process of experience and behavior, within which these gestures or symbols have the same or common meanings for all members of that group, whether they make them or address them to other individuals, or whether they overtly respond to them as made or addressed to them by other individuals. A universe of discourse is simply a system of common or social meanings (Mead, 1934:89-90).

These culturally-shared meanings which arise from an interpretive process sheds light on the collective character of the process. Although one can advance the argument that an individual has the ability to engage in this interpretive process alone, through thinking, however, individual thought is not the origin of socially-shared definitions. Mead contends that thinking is made possible through interaction with others. In this sense, thinking is really a social activity. Therefore, meanings of objects and events are shared in a double sense: not only do people hold common meanings but they also participate collectively in creating them.

Further, these shared meanings which have arisen through social interaction aid in determining the behaviour of individuals. In this sense, symbols may be said to have motivational significance. For example, if we define an object as a chair, by virtue of this definition determines how we will act toward it. That is, we know that a chair is used to sit upon and not to place one's dishes upon. For Mead then, symbols are motives.³

Explicit in Mead's theory is the notion that individuals are self-conscious beings; they possess selves and minds which although absent

at birth, emerge as a result of the individual's participation in the social world.

In terms of the nature of mind, Mead states that the mind is a unique human characteristic which arises in the evolutionary process when the impulsive behaviour of the individual is hindered as he attempts to adapt to his environment. Mind, for Mead develops out of the non-mental behaviour of pre-human biological forms.

Mead contends that the lower animals respond to the environment but are neither able to understand factors that affect their behaviour, nor are they able to conceive of alternative behaviours. In contrast however, humans are able to select out and indicate to themselves and others the meanings of certain environmental features to which they are responding. In this sense, individuals are able to achieve control over the stimuli to which they wish to respond:

Mentality simply comes in when the organism is able to point out meanings to others and itself...Mentality resides in the ability of the organism to indicate that in the environment which answers to his responses, so that he can control those responses in various ways... Mentality in our approach simply comes in when the organism is able to point out meanings to others and to himself (Mead, 1934:132).

For Mead, mind is the mechanism of control over meaning. It is a process that functions to serve the needs of individuals in their environmental adjustments.

Mead conceives of mind not as a substance but as a social product that emerges out of the social process and is made possible by meanings

and symbols which are social in character. This is rendered possible through language. Mead asserts that only when an individual has acquired a self and is able to use significant symbols is he able to exercise mind in relation to certain objects. Thus, in this sense social consciousness is historically prior to physical consciousness.⁴ Mind and social consciousness emerge when gestures stimulate implicitly in the actor the same response as in others explicitly.

Just as mind is a social product that arises through interaction with others, Mead conceives of self in a similar manner. Specifically, he asserts that self is not initially present at birth; it develops in the social process and undergoes continual development through the life of the individual. Mead contends that self is not wholly impregnated in society for once it has arisen, it is able to provide social experience for itself. Thus, while the self can be regarded as a social structure, it is also a process within the larger, ongoing social structure:

The self has a character which is different from that of the physiological organism proper. The self is something which has a development; it is not initially there at birth but arises in the process of social experience and activity, that is, develops in the given individual as a result of his relations to that process as a whole and to other individuals within that process...The self...is essentially a social structure, and it arises in social experience. After a self has arisen, it in a certain sense provides for itself its social experiences, and so we can conceive of an absolutely solitary self (Mead, 1964:199; 204).

For Mead, the distinctive nature of the self is found in the ability of the individual to be an object unto itself. Mead (1934:150)

contends that an individual has the ability to be both subject and object by 'taking the role of the other':


The individual experiences himself as such, not directly, but only indirectly from the particular standpoints of other individual members of the same social group, or from the generalized standpoint of the social group as a whole to which he belongs. For he enters his own experience as a self or individual, not by becoming a subject to himself but only in so far as he first becomes an object to himself just as other individuals are objects to him or his experience; and he becomes an object toward himself only by taking the attitude of other individuals toward himself within a social environment or context of experience and behavior in which both he and they are involved (Mead, 1934:138).

For Mead then, consciousness of self occurs when the individual is able to take the organized attitudes of others toward himself. Specifically, consciousness of self occurs through a type of communication utilized by what Mead (1934:67) refers to as 'significant symbols'—gestures that stimulate implicitly in oneself the same response that they stimulate explicitly in others. In short, self is conceived of as a social product that is made possible by language. One develops a self and becomes conscious of his self by applying words and meanings to his being that he obtains from society. Thus, self is conceived as a symbolic or linguistic construct that arises through social interaction:

It is in the social process itself that is responsible for the appearance of the self; it is not there as a self apart from this type of experience (Mead, 1934:40).

Having outlined the general nature of the social self, this

discussion will now briefly examine the conditions within which self originates and develops. As was previously stated, individuals are born into the world without a self. Self is a product of social interaction, which during the early stages of one's life is unconscious. In terms of a newborn baby, his needs such as food and shelter are met within a social context. Mother and baby interact with one another but only at a biosocial level. In this sense, the child is merely engaging in unconscious social behaviour or what Mead (1934:167) refers to as a 'conversation of gestures.' Self evolves as a result of this unconscious behaviour. As a child gets older, he is able to take the attitudes of others toward himself. Significant symbols and language emerge when the child is able to complete an inhibited action on the level of his imagination. Whereas consciousness and meaning arise out of unconscious communication within interaction, it is in this same process that self arises. Through this process, the individual is able to take the role of the other. In short then, explicit in Meadian theory is the idea that consciousness, meaning, self and facility with significant symbols are merely different phases of the same process.



In his discussion of the genesis of the self, Mead distinguishes between two stages: the play stage and the game stage. Genesis of the self involves the individual gaining the capacity to order experience in terms of social roles. That is, in the early stage of development (the play stage), the child 'plays at' being various people. For example, he plays at being father, policeman, teacher, etc. At this point, the child takes the role of particular others. It is through this play stage that

the child gains facility in organizing the attitudes of others in terms of social roles.

Not only must the individual learn to take the particular attitudes of individuals separately, but he must also learn to take the attitudes of the organized society collectively, or what Mead (1964:219) refers to as the 'generalized other.' This phase, which is termed by Mead as the 'game stage' may be likened to the game of baseball:

The fundamental difference between the game and play is that in the latter the child must have the attitude of the other players in that game. The attitudes of the other players which the participant assumes organize into a sort of unit, and it is that organization which controls the response of the individual (Mead, 1964:218).

In the game stage, the individual is placed in situations where he is forced to take on a number of social roles at the same time--he is forced to respond to the expectations of many individuals at once. In the game of baseball for example, the person has to visualize the attitudes and expectations of the entire team as over against the particular social roles. In this context, he must learn to abstract a general role out of particular roles--a generalized other that represents the organization of the entire social group. Only when the individual is able to take the attitudes of the generalized other toward himself is he able to possess a fully-developed self:

In the play stage, the individual's self is constituted simply by an organization of the particular

attitudes of other individuals toward himself and toward one another in the specific social acts in which he participates with them. But at the second stage in the full development of the individual's self, that self is constituted not only by an organization of these particular individual attitudes, but also by an organization of the social attitudes of the generalized other or social group as a whole to which he belongs. These social or group attitudes are brought within the individual's field of direct experience and are included as elements in the structure or constitution of his self, in the same way that the attitudes of particular other individuals are... So the self reaches its fullest development by organizing these individual attitudes of others into the organized social or group attitudes, and by thus becoming an individual reflection of the general systematic pattern of social or group behavior in which it and its others all are involved....(Mead, 1964:222).

At this point, it is worthy to make brief mention of the phases of self as distinguished by Mead. Explicit in Mead's theory is the notion that self is not merely an importation of the organized set of attitudes of others. In the self, there is involved a response of the person whose self it is. Mead distinguished between the 'I' and the 'me', the former representing the response of the individual to the organized attitudes of others, and the latter representing the individual's importation of the generalized attitudes of the community. These two phases are parts of the self that evolve in symbolic communication:

The 'I' is the response of the organism to the attitudes of the others; the 'me' is the organized set of attitudes of others which one himself assumes. The attitudes of the others constitute the organized 'me,' and then one reacts toward that as an 'I' (Mead, 1964:230).

For Mead then, self is conceived of as a process that moves in and out of these two phases. The 'me' represents a reflection of the existing social process; it allows the individual to orient his behaviour toward the organized attitudes of the community. The 'I' represents the subjective aspect of social life; it symbolizes the unpredictable, illusive aspects of the individual, what Mead (1934:117) terms as the 'fictitious I' and provides the basis for novelty.

Although the 'I' and the 'me' appear in experience as distinct and separate characteristics of the individual, it is apparent that they are really parts of a single entity. With reference to these phases, Mead points out that self is incapable of appearing in consciousness as an 'I' but can only do so as a 'me.' To quote Mead:

Such an 'I' is a presupposition, but never a presentation of conscious experience, for the moment it is presented it has passed into the objective case, presuming, if you like, an 'I' that observes—but an 'I' that can disclose himself only by ceasing to be the subject for whom the object 'me' exists (1913:374).

Just as mind and self were conceived by Mead as being symbolic or linguistic constructs that arise in social interaction, it logically follows that he viewed society in the same manner.

For Mead, society is a process in which mind and self emerge and change. Humans participate in two qualitatively different social processes: the biosocial and the symbolic, the symbolic emerging out of the biosocial:

The behavior of all living organisms has a basically social aspect: the fundamental biological or physiological impulses

and needs which lie at the basis of all such behavior--especially those of hunger and sex, those connected with nutrition and reproduction--are impulses and needs which, in the broadest sense, are social in character or have social implications since they involve or require social situations and relations for their satisfaction by any given individual organism and they thus constitute the foundation of all types or forms of social behavior, however simple or complex, crude or highly organized, rudimentary or well developed (1934:227-228).

Mead contends that human symbolic interaction arises out of this simple social interaction involving organisms. It is out of this symbolic interaction that mind, self and society evolve.

In each social process, be it either biosocial or symbolic, the fundamental unit is the act, and society may be conceived of as a coordinated series of actions. For Mead, human societies are structured with regard to the generalized attitudes of others--attitudes that dictate similar responses. An institution, in Mead's view, is comprised of a grouping of such common responses. It follows then that society is comprised of these institutions. In sum, society is viewed as an arrangement of the generalized attitudes of others.

While Mead conceives of society as a process that evolves through time, he also possesses a similar conception of social structure (Hornosty, 1980:see 3.4). In contrast to Durkheim who argues that society is sui generis in nature, Mead in his theory attempts to explain individual actions in their relation to society. Mead (1934:7) asserts:

For social psychology, the whole (society) is prior to the part (the individual), not the part to the whole; and the part is explained in terms of the whole, not the whole of the part or parts.

For Mead then, society is viewed as an 'evolving, functionally differentiated constellation of social roles' (1934:7).

Having examined the fundamental assumptions of Meadian symbolic interactionism and its basic concepts, this discussion will now turn to an outline of the labelling theory of deviant behaviour--a theory clearly rooted in the interactionist tradition.⁵

The Labelling Theory of Deviant Behaviour

The emergence of labelling theory in 1960 developed out of ideas first expounded by Tannenbaum in 1938 and later more systematically developed by Lemert in 1951. In reaction against the traditional theories of deviant behaviour which centred on an examination of the causes and consequences of various forms of deviance,⁶ Tannenbaum and Lemert placed primary emphasis on the societal reaction to deviant behaviour.

Tannenbaum, in his discussion of the role that societal stigmatization plays in creating a criminal career states:

The process of making the criminal, therefore, is a process of tagging, defining, identifying, segregating, describing, emphasizing, making conscious and self-conscious; it becomes a way of stimulating, suggesting, emphasizing, and evoking the very traits that are complained of...The person becomes the thing he is described as being. Nor does it seem to matter whether the valuation is made by those who would punish or by those who would reform...The harder they work to reform the evil, the greater the evil grows under their hands. The persistent suggestion, with whatever good intentions, works mischief, because it leads to bringing out the bad behaviour that it would suppress. The way out is then a refusal to dramatize the evil (1938:19-20).

In a more systematic attempt at theoretical explication, Lemert provides much of the foundation upon which current labelling theory is built:

...we start with the idea that persons and groups are differentiated in various ways, some of which result in social penalties, reaction and segregation. These penalties and segregative reactions of society or the community are dynamic factors which increase, decrease and condition the form which the initial differentiation or deviation takes...The deviant person is one whose role, status, function and self-definition are importantly shaped by how much deviation he engages in, by the degree of its social visibility, by the particular exposure he has to the societal reaction, and by the nature and strength of the societal reaction (1951:22, 23).

Examination of the major tenets of labelling theory reveals that it is clearly oriented within an interactionist framework.⁷ A first, fundamental assumption of labelling theory, corresponding with the Chicago school, posits that one is not able to fully comprehend deviant behaviour in terms of the actions themselves but only if it is realized that deviant behaviour, like 'normal' behaviour involves social interaction with others. For labelling theorists, deviance is conceived of as a product of social interaction between the actor committing a deviant act and the audience who responds to his behaviour. In short, a central tenet of labelling theory is not concerned with action per se but with societal reaction. As Erikson aptly expresses it, labelling deviance is contingent upon the reaction of an audience:

From the sociological standpoint, deviance can be defined as a conduct which is generally thought to require the attention of social control agencies--that is, conduct about which 'something should be done.' Deviance is not a property inherent in certain forms of behavior; it is a property conferred upon these forms by the audiences which directly or indirectly witness them. Sociologically then, the critical variable in the study of deviance is the social audience rather than the individual person, since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviation (1962:308).

Similarly, Becker states:

From this point of view, deviance is not a quality of an act a person commits but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom the label has been successfully applied (1963:9).

Kitsuse supports the emphasis on societal reaction when he says:

Forms of behavior per se do not differentiate deviants from non-deviants; it is the response of conventional and conforming members of society who identify and interpret behavior as deviant which sociologically transforms people into deviants (1962:253).

Conceptualization of deviant behaviour as a 'reaction process' of society leads to a second related assumption of labelling theory which asserts that the demarcation between conventional and unconventional behaviour is disputable and ambiguous. According to the labelling perspective, what are considered acceptable and unacceptable behaviours is entirely relative. As Scheff (1975:10) argues, labelling is not an auto-

matic process: whether one is labelled a 'deviant' is contingent upon several factors such as:

- (1) the visibility of the rule-violation;
- (2) the power of the rule-violator in relation to the individuals responding to this violation;
- (3) the severity of the violation;
- (4) the tolerance level of the community;
- (5) the availability of the society to channel the reaction to something other than labelling.

In short, proponents of labelling theory posit a reciprocal process operating between the actor and his audience. Rather than conceiving of deviance as 'objectively given'⁸ and attempting to gather descriptive data on rule-violators from the official records, labelling theorists, in contrast, conceive of deviance as subjectively problematic. For advocates of the labelling perspective: "processes of social interaction must be inspected to ascertain the conditions under which deviance is defined and what consequences flow from that definition" (Rubington and Weinberg, 1973:1-2).

Labelling theorists, in their conceptualization of deviance as subjectively problematic, focus their analyses upon issues generated in the interactions between the actor and others in society. That is, this perspective focuses on the following: (1) those who define an individual as a deviant; and (2) the individual who has been negatively labelled and stigmatized by others as being 'deviant.' In terms of the former, pro-

ponents of this perspective focus upon: (a) the conditions under which an individual is segregated and labelled a deviant; (b) how the individual is cast into the deviant role; (c) the behaviour of others toward this redefined person; and (d) the positive or negative value that others place upon the facts of deviance (Rubington and Weinberg, 1973:2).

In terms of the latter, labelling theorists focus upon the actor himself who has been negatively labelled and stigmatized by others as 'deviant.' Specifically, this perspective centres upon: (a) the reaction of the actor to the label bestowed upon him; (b) the manner in which he/she adopts the deviant role; and (c) the extent to which the actor adopts this new conception of self (Rubington and Weinberg, 1973:3).

Career, Status and Identity Transformation

Proponents of the labelling perspective often employ the concept of 'career' in their analyses of deviant socialization processes.

In traditional form, the concept of 'career' was employed in relation to a profession or occupation where it referred to the course of an individual's expected or actual occupational activities from one stage to another. That is, this concept specifically referred to the advancements or promotions within a certain occupation or profession (Goffman, 1961:127).

More broadly however, sociologists have expanded the meaning of this concept to refer to the temporal sequencing of actions in any sphere of life and not solely in reference to occupations.⁹

According to Everett C. Hughes (1958:67), the concept of career

may be viewed as:

...the moving perspective in which people orient themselves with reference to the social order...Institutions are but the forms in which the collective behavior and collective action of people go on. In the course of a career, the person finds his place within these forms, carries on his active life with reference to other people, and interprets the meaning of the one life he has to live.

And Tamotsu Shibutani (1962:137) writes:

Career lines are organized, and there is usually an orderly sequence of steps through which one moves from apprenticeship to mastery. It is in terms of such ladders that aspirations are shaped, and a person who is on his way measures his progress by comparing himself with his predecessors, not with outsiders...Common memories are built up and reinforced within the limited communication network.

Further, Erving Goffman (1961:168) states:

The moral career of a person of a given social category involves a standard sequences of changes in his way of conceiving of selves, including, importantly, his own. These half-buried lines of development can be followed by studying his moral experiences--that is, happenings which mark a turning point in the way in which the person views the world--although the particularities of this view may be difficult to establish...By taking note of the moral experiences and overt personal stands, one can obtain a relatively objective tracing of relatively subjective matters. Each moral career, and behind this, each self, occurs within the confines of an institutional system...The self, then, can be seen as something that resides in the arrangements prevailing in a social system for its members...the self dwells in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it.

In short, the concept of career may be viewed as a movement of individuals through a structure of society. The different stages in a career symbolize the transformation of the person's status and identity,¹⁰ and allows him to view himself as moving along a continuum. Hughes (1958:72) contends that the concept of career is two-sided in nature. That is, objectively this concept can be conceived of as a passage through various roles and statuses. Subjectively, the concept of career may be conceived of as being comprised of individuals' self-images and identities as they move through different institutions and organizations.

For labelling theorists then, careers occur within institutional frameworks where neophytes are processed and socialized into various roles and statuses, which in turn, affect their conceptions of self. In short, many deviant identities and careers are molded, developed and sustained in what have been termed as 'people-processing institutions.'¹¹

This term...refers to a type of social institution in which human beings constitute both the raw materials and the products of organizational work. Although all social institutions are involved in some degree in people-processing activities, this term is properly restricted to those whose primary goal is the shaping, reshaping, removing, overhauling, retooling, reassembling, and recording the physical, psychological, social, legal or moral aspects of human objects (Kitsuse, 1970:163).

As a consequence of this institutional processing, the individual is confronted with a new social identity--an identity which is incompatible with his prior conception of self. The individual may initially reject this redefinition of self as 'deviant' but through reinforcement

from institutional staff (and sometimes even from his peers), the individual is forced to accept this new definition of self--a social definition that may subsequently lead to his stigmatization by society. In essence, the institution's perception of the individual produces a self-fulfilling prophecy whereby the individual comes to be molded in the image that the institutional staff have of him.]

In conclusion, this chapter has attempted to introduce the reader to the theoretical stance adopted in this thesis. Specifically, the fundamental assumptions and concepts of symbolic interactionism were described. Secondly, a brief sketch of the labelling theory of deviant behaviour and its related concepts was presented, a perspective that will be employed in the subsequent analysis.

The next section will present a review of the existing literature on mental patients, psychiatric institutions, and the nature of mental illness in general.

FOOTNOTES FOR CHAPTER TWO

- 1 See, George Herbert Mead (1932), (1934), (1936), and (1938).
- 2 For a detailed discussion of the tenets of symbolic interactionism, see the following: Blumer (1966), (1969); Rose (1962); Manis and Meltzer (eds.) (1967). In recent years, various criticisms have been levelled against certain tenets of symbolic interactionist theory by both in-house critics (interactionists) and outsiders (non-interactionists). See for example: Kolb (1944:291-296); Meltzer (1959), (1972:4-22); Huber (1973:278-284); Lichtman, (1970:75-94); Gouldner (1970); Shaskolsky (1970:7-30); Ropers (1973:15-28); Kanter (1972:77-92); Smith (1973:62-75); Denzin (1979:922-934); Kuhn (1964: 61-84); Manis, Petras and Reynolds (1975:83-115).
- 3 Not only do social groups provide the individual with meanings and definitions about appropriate forms of action, but they also function to provide rationales for behaviour. As C.W. Mills (1940:907) notes, "motives are accepted justifications for present, future, or past progress of acts." In this sense then, motives are conceptualized as socially learned expressions that serve to provide the individual and others with rationalizations for behaviours. See also Schutz (1967) for a discussion of motives as being both rationalizations for behaviour as well as plans of action.
- 4 This idea is fully expounded in Mead (1910:178).
- 5 For evidence in support of the labelling perspective, see: Scott (1970); Jewell (1952:32-36); Mercer (1966:21-34); Freidson (1966a:82-93); Lemert(1962:2-25).
- 6 A detailed discussion of the traditional approaches to the study of social problems may be found in the following: Bernard (1957); Davis (1975); Herman (1980); Matza (1969); and Rubington and Weinberg (eds.) (1977).

- 7 For a discussion of the various criticisms of labelling theory see: Fine (1977:166-190); Gove (1970:873-884); Davis (1972: 447-474), (1975:197-234); Gibbs (1966:9-14). It is beyond the scope of this discussion to deal with the various criticisms levelled against labelling theory. This chapter will deal solely with the underlying assumptions of this perspective in relation to their subsequent importance for this research.

- 8 Rubington and Weinberg (1973:1-4) provide an elaboration of the two approaches to the study of deviant behaviour.

- 9 See: Sykes (1958); Bryan (1964); Weinberg (1966); Crespo(1973: 129-145); and Hall (1948:327-336).

- 10 For a discussion of a sociological theory of identity transformation, careers, and changes in status, see Glaser and Strauss (1971). See Roth (1963) and Davis (1963) for an examination of the careers of the tuberculosis patient and the polio patient respectively. Anthropologists have also been interested in examining transformations in identity and alterations in status. See for example: Van Gennep (1960); Turner (1969) and Gluckman (1962).

- 11 This term, originating with Goffman (1961) has been employed by Freidson (1966b); Cicourel and Kitsuse (1963); and Bittner (1967).

CHAPTER THREE

LITERATURE REVIEW

The history of man's attempt to understand his world in order to explain, control and predict events inevitably involves the utilization of conceptual models or classification schemes. It is through these various theories and conceptual frameworks that man selects, orders and explains his observations--through these perspectives, courses of action are determined.

One such problem man has sought to understand concerns the nature of 'insanity'--a concern which has resulted in the construction of numerous 'models of madness.'¹

This chapter serves to present to the reader a review of the existing literature on mental patients, psychiatric institutions and the nature of mental illness in general. Specifically, this chapter focuses upon four major models of insanity:²

- (1) the medical model

- (2) the sociological models:
 - (a) the structural-functionalist model
 - (b) the existential-phenomenological model
 - (c) the social-role model

This discussion centres upon the fundamental tenets of each conceptual model, the primary figures who have adopted these models in their research endeavours concerning insanity, followed by an examination of the strengths and weaknesses of each model. The chapter concludes with a discussion of the model adopted for the present research study.

The Medical Model of Mental Illness

Examination of the medical model of mental illness reveals that it is based upon two fundamental tenets:

- (1) mental disorders are conceptualized as 'diseases;'
- (2) the notion of clinical universalism.

In terms of the former, advocates of the medical model contend that mental disorders are diseases located within the individual and should be treated as such--they have biological or genetic causes and thus, should be treated in a manner similar to diseases of the body. Diseases, according to this model are conceived of as disturbing conditions that can be cured or alleviated through the proper care of trained physicians. Within this model, the physician is placed in an authoritarian role for he is granted the right to explore both the physical and psychological dimensions of the individual--a right that entails an obligation to help the patient. The patient is conceptualized as a 'sick person' in need of psychiatric care--a role characterized by

dependency and lack of responsibility for self.

Aubrey Lewis (1967:179-194), in his discussion on the nature of health and illness asserts that the medical model of mental illness contains three types of data: (1) the objective--a functional or behavioural disorder that is visible to the physician; (2) the subjective--the complaints of the patient; and (3) classification--the placement of signs and symptoms within a clinical typological classificatory system. Adopting an objective theoretical stance and scientific classification scheme, proponents of this model seek to examine, define and treat the observable behaviour of the patient. Specifically, advocates of the medical model examine the symptomatology of the patient upon which a diagnosis is based, and subsequently prescribe a form of treatment. Siegler and Osmond (1974: 24), advocating a medical model stance aptly sum up this position:

First, a patient voluntarily comes to a building called a 'hospital' where he agrees to be called a 'patient' and where he is referred to as a 'case.'
 If he is unable to come on his own two feet, he may be brought by others who stand for him and for whom he would do the same. He then agrees to be handled with extraordinary physical intimacy by strangers called 'doctors' in a way allowed to no one else, not even a sexual partner. The function of this examination is to find out what the patient 'has'--no what he 'is' or 'does.' This means: into what category of previously described illnesses does the patient best fit?...On the basis of diagnosis, the doctor may decide upon a treatment, which is what the doctor wants to do for the patient...This brings us to prognosis, another essential medical function. The doctor must maintain the patient's hope and his will to live, while giving him a realistic idea of the likely course and outline of the illness.

In short then, in this model mental illness is comprehended from an objective point of view and treated in a manner similar to other illnesses.

Man is conceptualized as a 'diseased' psychological or physiological entity--no attempt is made to understand mental illness from the point of view of the patient himself.

Further, explicit in this model is the notion that social criteria are irrelevant in the definition of mental illness. In Lewis' (1967:194) view, mental illness cannot be conceived in terms of negative societal reaction because negative reaction is a function of the norms and values of a society and the individuals who make those judgments. Moreover, according to Lewis non-conformity cannot be criterion of mental illness because it is usually expressed in terms of social role and is influenced by such factors as conflict, culture change etc. Therefore, Lewis dismisses social criteria for defining mental illness because they reflect value judgments and are culturally-relative in nature. As Lewis (1967:194) states:

...the criteria of health are not primarily social: it is misconceived to equate ill-health with social deviation or maladjustment.

For Lewis then, (as with other advocates of the medical model) mental illness is conceptualized as an abnormal state of the organism.

Whybrow (1972), in his discussion of the medical model, conceives of mental health and illness as relative conditions. Specifically, Whybrow (1972:334) asserts that:

...(mental health is the) ability in the human animal to adapt, organize, and respond to a constantly changing social, psychological and biological environment... Disease, therefore, on a continuum with health, may be seen to correspond with a compromising or a failure of these functions.

In this perspective, mental health is equated with successful biological and social adaptation while mental illness, conceived of as a disease, results from failure at such adaptations. Moreover, the medical model emphasizes the processural nature of mental health and illness³—few, if any, individuals are totally ill. Conversely, few, if any, so-called 'normal' individuals are completely free from emotional problems (Schwab and Schwab, 1978:122).

A second fundamental tenet of the medical model approach to the study of mental disorders involves the notion of clinical universalism.⁴ Essentially, proponents of this model contend that except for cursory variation in content, mental illnesses are virtually the same throughout the world. E.B. Forster (1962:35) aptly expresses this view:

Psychiatric syndromes or reactions, by and large, are similar in all races throughout the world. The mental reactions seen in our African patients can be diagnosed according to the Western textbook standards. The basic illness and reaction types are the same. Environmental, constitutional, and tribal background merely modify the symptom constellation. Basically, the disorders of thinking, feeling, willing and knowing are the same.

E.L. Margetts (1965:24), a cross-cultural psychiatrist also advocates this universalist stance:

The more I listen to the discussion of transcultural psychiatry, the more I am coming to believe that perhaps there is no such thing... (Psychiatrists) have not learned a great deal about it since the time of Kraepelin. As far as I am concerned, psychiatry is the same all around the world: the signs and symptoms of mental diseases are the same, the diagnoses are the same, and there is probably just as much possession syndrome in England as there is in equatorial Africa.

While the majority of proponents of the medical model are clinicians, some social scientists have asserted that the medical model best explains mental disorders. For example, sociologist Walter Gove (1970; 1975a; 1975b) adopts the medical model approach to the study of mental illnesses. Similarly, anthropologist Jane Murphy (1976) adopts this model with its universalist stance in her analysis of mental disorders. In a discussion that Western diagnostic labels are valid transculturally, Murphy (1976:1019) states:

The cross-cultural investigations suggest that relativism has been exaggerated by labeling theorists and that in widely different cultural and environmental situations sanity appears to be distinguishable from insanity by cues that are very similar to those in the Western world.

In summary, the medical model dismisses social/cultural factors in the definition of mental illness. Mental disorders are conceptualized as diseases located within the individual—they have biological or genetic causes and hence, should be treated similar to other illnesses. In this view, symptomatology of the disease determines the societal reaction rather than the converse.

Further, insofar as mental disorders are conceived as diseases, it logically follows for the clinical universalists that the symptoms should exhibit minimal cross-cultural variation. Clinicians assert that the symptomatology of mental illnesses are universal and societal reactions are similar cross-culturally. Murphy (1976:1025) aptly sums up this universalist stance:

If one defines intolerance of mental illness as the use of confinement, restraint or exclusion from the community (or allowing people to confine or exclude themselves), there does not appear to be a great deal of difference between Western and non-Western groups in intolerance of the mentally ill. Furthermore, there seems to be little that is distinctively cultural in the attitudes and actions directed toward the mentally ill, except in such matters as that an abandoned anthill could not be used as an asylum in the arctic or a barred igloo in the tropics. There is apparently a common range of possible responses to the mentally ill person, and the portion of the range brought to bear regarding a particular person is determined more by the nature of his behavior than the pre-existing cultural set to respond in a uniform way to whatever is labeled mental illness.

While many clinicians and social scientists advocate the medical approach to the study of mental disorders, others have found it unsatisfactory.⁵ One of the major criticisms of the medical model is its failure to include social processes in the examination of the nature of mental illness. That is, this conceptual framework is mainly concerned with the individual in contrast to the social system. Proponents of the medical model of mental illness seek genetic, biochemical and biological causal agents--dynamic systems that are located within the individual. In short, this model isolates the symptom from the social context within which it occurs. It merely postulates 'unconscious causes' of behaviour without examining the social context in which the behaviour occurs. In this sense, I would argue that the medical model is narrow in scope.

A second, related criticism centres on the model's contradictory position concerning the issue of cultural relativism. As Schwab and Schwab (1978:122) note, there exists a logical inconsistency in the

medical model of mental illness: on the one hand, the model presupposes societal norms and values--it posits a clinical universalist stance asserting that mental disorders exhibit similar symptomatology throughout the world and that different societies react to mental illness in a similar manner. On this basis, advocates of the medical model dismiss social/cultural factors in the definitional process of what constitutes mental illness. On the other hand however, the medical model implicitly states that within this perspective the patient supplies individual norms which are subsequently evaluated by psychiatrists in terms of the general norms of the psychiatric profession. Thus, I would conclude that the medical model is inconsistent in terms of its logic regarding the issue of cultural relativism.

6

A third limitation of the medical model centres on its derivation from the Darwinian notion of adaptation. Within this perspective, health is conceptualized as successful biological and social adaptation while illness (whether physical or mental) is conceived as a failure at such adaptations. As Schwab and Schwab (1978:122) note, this viewpoint is tautological in nature because it suggests that mental health and successful adaptation are synonymous. Aubrey Lewis (1967:185-186) aptly sums up this point:

...mental health cannot be equated with good social adaptation, as many have proposed, without risk of tautology: the valued and desired state which adaptation is to attain or maintain may itself turn out to be health.

Further, anthropologist Clyde Kluckhohn (1962:260-264) contends

that it is narrow to think in terms of adaptation:

We require a way of thinking that takes account of the pull of expectancies as well as the push of tension, that recognizes that growth and creativity come as much or more from instability as from stability, and that emphasizes culturally created values as well as the immediately observable external environment. (emphasis mine)

A fourth criticism levelled against the medical model of mental illness centres on its lack of utility and applicability. Within this model, mental disorders are conceptualized as diseases that are caused by certain biological, bio-chemical or genetic factors. However, in strict scientific terms the etiology of the majority of the mental illnesses remains unknown. While many clinicians speculate about the etiological factors concerning the nature of mental disorders, the empirical evidence is inconclusive at this point.⁷ Therefore, on this basis the medical model has difficulty in categorizing many of the interpersonal difficulties, problems in living and conflicts faced by individuals--it merely has applicability for the diagnosis and classification of some of the more clearly-delineated types of disorders such as organic brain syndromes.

A final criticism levelled against the medical model is its failure to focus on the patient from a subjective point of view--failure to comprehend his experiences, his definition of reality.⁸ Adopting an objective theoretical and scientific classificatory scheme, proponents of this model merely examine the observable behaviour of the patient--they look at the patient's actions as 'signs' of a 'disease' upon which a diag-

nosis is conferred and treatment is prescribed. However, this model does not allow one to understand mental illness from the point of view of the patient himself. In this model, man is merely viewed as a 'diseased' psychological or physiological entity--no attempt is made to understand the overall situation of the individual in society. In summary, this narrow clinical focus with its objective classification scheme and technical vocabulary prevent the psychiatrist from attaining a holistic understanding of the world of the mental patient.

The Structural-Functionalist Model of Mental Illness

In contrast to the medical model which views mental disorders as diseases located within the individual, the structural-functionalist model conceives of mental illness as an inherently social phenomenon. Talcott Parsons (1951b:453) in his discussion on the nature of mental illness asserts:

Seen in this perspective illness is to be treated as a special type of what sociologists 'deviant behavior.' By this is meant behavior which is defined in sociological terms as failing in some way to fulfill institutionally defined expectations of one or more of the roles in which the individual is implicated in the society. Whatever the complexities of the motivational factors which may be involved, the dimension of conformity with, versus deviance or alienation from, the fulfillment of role expectations is always one crucial dimension of the process. The sick person, is by definition, in some respect disabled from fulfilling normal social obligations, and the motivation of the sick person in being or staying sick has some reference to this fact. Conversely, since being a normally satisfactory member of social groups is always one aspect of health, mental or physical, the therapeutic process must always have as one dimension the restoration of capa-

city to play social roles in a normal way.

For Parsons, the primary definitional criteria of mental illness are based upon the social role performance of the individual.⁹ Parsons (1957:109) acknowledges that the etiological factors of mental illness may be biological, biochemical or genetic in nature--in this sense, mental illness is a state of the individual. However, "this state of the individual manifests itself and creates problems for the sick person as well as others in society with whom the individual interacts" (Parsons, 1957:109)--hence, mental illness may also be conceived of as a social phenomenon. In his discussion on the distinction between somatic and mental illness, Parsons (1957:109) states:

In the case of somatic illness the focus of disturbance seems to center in the relations between the body as a system and the personality. Somatic illness is in the first instance an 'intra-individual' phenomenon, and only secondarily a social phenomenon in that the functioning of the individual in his social relationships may be impaired through the ramifications of the central disturbance. Thus the primary focus of an acute infection is impairment in organic functioning...In the case of mental illness...the focus of disturbance is the relations between the personality of the individual and the social system or systems in which he participates. The etiological or diagnostic factors may of course be mainly somatic. The crucial issue, however, is the problem occasioned by the presence in the community of a person in this condition. A mentally ill person is then...a person who by definition cannot get along adequately with his fellows, who presents a problem to them directly on the behavioral level.

In short, within this model mental illness is conceptualized not merely as a 'condition' but also as a social role--a role characterized by an incapacity of the individual to perform normally-expected roles and ob-

ligations.

Parsons (1958:108) in his discussion on the social genesis of mental illness asserts that mental disorders develop as a result of the inability of the individual to cope with 'strains' imposed upon him in the context of the social process:

There is a set of mechanisms in the operation of which social system and personality aspects are interwoven, which make possible the many complex adjustments to changing situations which always occur continually in the course of social processes. It is when the mechanisms involved in these adjustive processes break down ('adjustive' as between personalities involved in social interaction with each other) that mental illness becomes a possibility, that is, it constitutes one way in which the individual can react to the 'strains' imposed upon him in the course of social process.

For Parsons (1951b:454), the pathogenic strains centre around two elements: (1) the support system of the individual; and (2) the value patterns of the social group. In terms of the former, support may be defined as unconditional acceptance of the individual as a member of the social group—his membership is not provisional upon his behaviour. In terms of the latter, this aspect centres upon the maintenance of the value patterns by the group members. For Parsons (1951b:454) the major sources of strain in social relationships result when prominent group members reject the group norms and values, when members evade their responsibilities for the enforcement of norms, and when the norms must be 'legally' enforced.

Parsons (1951b:455) contends that mental illness may be one manner in which the individual reacts to the various strains placed upon him by society. In this model, insofar as mental illness is conceptualized as a form of deviant behaviour, it is not a unique phenomenon; rather, it

represents one type of aberrant behaviour within a larger category of deviance. For Parsons, mental illness merely constitutes one set of alternatives which are open to the individual in response to these strains-- other alternatives include the formation of delinquent gangs, the development of religious sects, etc.

In his conception of mental illness as not merely a 'condition' but also a social role, Parsons (1958:117) details four features of this 'sick role:' (1) the individual cannot be held responsible for his incapacity; (2) his incapacity serves as a legitimate basis for exemption from normal role obligations; (3) being defined as 'mentally ill' allows the individual to be able to deviate 'legitimately.' However, this legitimation is provisional upon the person's recognition that to be ill is undesirable--thus, he has an obligation to attempt to regain his health; (4) insofar as the sick person is unable to 'cure himself,' he must therefore seek the help of competent personnel in order to achieve this goal.

Within this framework, the sick role functions as a mechanism of social control. That is, being categorized as mentally ill places the individual in the position of being defined as a patient in need of help. Thus, he is expected to cooperate with the institution and its officials who bestow this definition upon him. In this sense, the sick role serves as a mechanism of social control for it allows the patient to deviate legitimately within institutionally-defined limits, thereby maintaining the equilibrium of the social system.

Moreover, the sick role also functions to isolate the deviant from interaction with other deviants. It prevents him from joining deviant sub-

cultures which present a threat to the stability of the society. The sick role serves to place the individual in contact with re-equilibrating influences:

The role of illness, that is to say, channels those categorized as belonging in it into contact with therapeutic agencies. It is therefore involved in both negative and positive mechanisms of social control, negative in that the spread of certain types of deviance is inhibited, positive in that remedial processes are facilitated (Parsons, 1958:118).

Further, in Parsons' perspective the sick role functions to separate the deviant from the non-deviant. Specifically, this role serves to insulate the sick from the healthy and reinforces the latter not to fall ill. Similar to Durkheim's (1956:103) conception of crime as serving positive functions for society in terms of strengthening normative consensus, so too Parsons (1958:118) views illness in a similar light. In Parsons's view, the sick role serves to reinforce healthy individuals' motivations not to fall ill. For Parsons (1951a:477):

The sick role is...a mechanism which...channels deviance so that the two most dangerous potentialities, namely group formation and successful establishment of the claim to legitimacy are avoided. The sick are tied up, not with other deviants to form a 'subculture' of the sick, but each with a group of non-sick, his personal circle and, above all, physicians. The sick thus become a statistical status class and are deprived of the possibility of forming a solidary collectivity. Furthermore, to be sick is by definition to be in an undesirable state, so that it simply does not 'make sense' to assert a claim that the way to deal with the frustrating aspects of the social system is 'for everybody to get sick.'

While we can credit Parsons for developing a social definition of mental illness, nevertheless, there are many weaknesses in this model. ¹⁰

Specifically, one of the major criticisms of Parsons' model of mental illness centres on its lack of consideration of the patient from a subjective point of view. In this model, Parsons focuses upon the interrelations between actors and the static patterns formed out of institutionalized expectations that function to constrain the actions of the individuals. However, no attempt is made to study the actions of the actors per se. Moreover, examination of the underlying tenets of his conception of the 'sick role' imply that the patient readily accepts the institution's definition of himself as being mentally ill; further, it implies that the patient wants to cooperate with trained officials in order to regain his health--assumptions made by Parsons without taking into account the feelings of the patient himself. Within this perspective then, mental illness is analyzed solely from the institution's point of view--no consideration is given to the understanding of mental illness from the patient's point of view.

A second weakness of the structural-functionalist model is its failure to examine societal reaction factors in the analysis of mental illness. Specifically, this model centres on the causal factors of mental illness in terms of role strain, to the sole exclusion of the social processes by which individuals come to be defined and treated as mentally ill. The underlying assumption of this model is that certain types of behaviour are per se deviant and are defined as such by the rest of society--in this perspective, societal reactions are conceptualized as being constant rather than problematic in nature. In sum, I would argue that the neglect of

societal reaction factors in the study of mental illness represents a major shortcoming of the structural-functionalist model.

The Existential-Phenomenological Model of Mental Illness

In reaction against the medical model of mental illness, the existential-phenomenological perspective asserts that objective theory and scientific classifications must be disbanded and primacy be given to the individual and his unique experiences in the world.¹¹ For advocates of this framework, the medical model of mental illness is seen to pose two central problems: (1) it employs a reductive terminology that serves to depersonalize the patient into components; and (2) it utilizes a 'vocabulary of denigration' that attempts to provide a pretense of objective neutrality while actually functioning to distance the patient from the patient's being-in-the-world (Gordon, 1971:53-54). The existential psychiatrist, R.D. Laing (1965:18) poses this central question:

How can I go straight to the patients if the psychiatric words at my disposal keep the patient at a distance from me? How can one demonstrate the general human relevance and significance of the patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity?

Rollo May (1967:4) also expresses this concern:

Can we be sure...that we are seeing the patient as he really is, knowing him in his own reality; or are we seeing merely a

projection of our own theories about him?...the crucial question is always the bridge between the system and the patient--how can we be certain that our system, admirable and beautifully wrought as it is may be in principle, has anything whatsoever to do with this specific Mr. Jones, a living, immediate reality sitting opposite us in the consulting room. May not just this particular person require another system, another quite different frame of reference? And does not this patient, or any person for that matter, evade our investigations, through our scientific fingers like seafoam precisely to the extent that we rely on the logical consistency of our own system?

Rejecting the objective theoretical stance and nosological classificatory scheme of the medical model, proponents of the existential-phenomenological model offer in its place, an approach that attempts to grasp sets of elements as totalities--elements which must be understood from the subjective point of view of the patient. As Michel Foucault (1976:45) states:

It is no longer enough to say that the child's fear is the cause of the adolescent's phobias; we must rediscover beneath that original fear and beneath its morbid symptoms the same style of anxiety that gives them their significative unity. Discursive logic is out of place here: it becomes tangled in the threads of delusion and exhausted in an attempt to follow the reasonings of the paranoiac. Intuition goes further and more quickly when it succeeds in restoring the fundamental experience that dominates all pathological processes...At the same time as it reveals in a single gaze essential totalities, intuition reduces, to the point of extenuating it, the distance that constitutes all objective knowledge: the naturalist analysis envisages the patient with a distance of a natural object... Intuition, leaping into the interior of morbid consciousness, tries to see the pathological world with the eyes of the patient himself: the truth it seeks is of the order not of objectivity, but of intersubjectivity.

Advocates of the phenomenological-existentialist model contend that

one cannot merely observe the symptomatology of the patient's behaviour and subsequently bestow a diagnostic label upon him but rather, one must relate the patient's actions to his manner of experiencing the situation. By focussing solely upon the patient's behaviour as 'signs' of some pathological entity, one is already imposing his own being-in-the world onto that of the patient. It is the aim of the existential-phenomenological perspective to achieve a subjective understanding of the world of the mental patient by entering his experience:

...the therapist must have the plasticity to transpose himself into another strange and even alien view of the world... Only thus can he arrive at an understanding of the patient's existential position...What is necessary is to know how the patient is experiencing himself and the world, including oneself (Laing, 1965:34).

In short, for the existential-phenomenologist, "the world of the particular patient must be grasped from the inside, be known and seen as far as possible from the one who exists in it" (May, 1967:56).

When one attempts to examine mental illness from an objective point of view, the world of the mental patient may seem strange and bizarre in nature--a world that is incomprehensible to the outsider. However, when one subjectively enters the patient's experience, he often discovers a meaningful and intelligible world. It is the aim of the existential-phenomenological perspective to achieve an understanding of the patient's experience of his world and himself.

While rejecting the objective theoretical stance of the medical model, proponents of the existential-phenomenological perspective also dismiss its nosological classification scheme. Specifically, although ad-

vocates of this model assert that the etiological factors of certain mental illnesses may be biological or psychological in nature--however, what is important for the existential-phenomenologist is not merely to conceive of mental illness as an organic or psychological pathological entity, but rather to view it in terms of the entire experience of the patient:

...whether its first designations are organic or psychological, the illness concerns the overall situation of the individual in the world; instead of being a physiological or psychological essence, the illness is a general reaction of the individual taken in his psychological and physiological totality (Foucault, 1976:9).

In terms of the strengths of this model, we can credit the existential-phenomenological approach for attempting to achieve an empathetic understanding of the mental patient's experience of his world and himself. In contrast to the models previously described which seek to understand mental illness from an objective standpoint, the existential-phenomenological model seeks to grasp the world of the mental patient from the inside.

One of the major shortcomings of this approach centres on its non-processual nature. That is, proponents of the existential-phenomenological model focus on the situation of the mental patient--his experiences in the world, to the sole exclusion of the social processes by which individuals come to be defined and treated as mentally ill, and the consequences of this social definition for self-attitudes and further participation in society.

The Social-Role Model of Mental Illness

Advocates of the labelling theory of mental illness, in reaction against the medical model, offer in its place a model which has been termed variously as the 'cultural deterministic approach,'¹² the 'sociological model,'¹³ or the 'social-role model.'¹⁴

In contrast to the medical model which conceives of mental disorders as disease entities located within the individual, the social-role model places primary emphasis on the social processes by which an individual comes to be defined as mentally ill.¹⁵ Subsumed under the heading of deviant behaviour, the social-role model conceptualizes mental illness as an arbitrary label ascribed to certain types of behaviour. In this perspective, mental illness is not the result of any inherent feature which characterizes the mentally ill; rather, it is a social definition bestowed upon individuals as a consequence of certain types of behaviour. As Spitzer and Denzin (1968:2) suggest:

...mental illness is not a function of the content of an individual's acts (his symptomatology), but is, instead, defined by the reactions to his acts and the categorizations of them by those with whom he is in association. Certain behaviors viewed as violating the rules of conduct imposed by various audience members will earn him the label 'mentally ill' and may result in the instigation of steps for the treatment of the 'illness.'

Examination of the social-role model of mental illness reveals that it is comprised of three fundamental components:

- (1) societal reaction to residual rule-violations is the major element in the development of the mentally ill role;
- (2) mental illness is comprised of culturally-conditioned deviant social roles--roles conditioned by the same order of forces as 'normal' roles;
- (3) labelling an individual as 'mentally ill' has important consequences for his attitudes toward self and for his further participation in society.

According to this model, the majority of psychiatric symptoms are instances of what Scheff (1966:33) terms as 'residual deviance.' In our society, we possess a number of terms for the categorization of many rule violations such as perversion, crime, drunkenness, etc.--each of these terms being derived from the type of norm broken and also from the type of action involved. However, as Scheff (1966:34) suggests, there exists a number of violations for which society provides no explicit classification or label. Mental illness, in this model is conceived as a residual category of deviant behaviour having no clearly defined label.

Advocates of the social-role model contend that residual rule-breaking evolves from diverse sources, such as external stress, psychological sources, organic causes and from willful acts of innovation or defiance (Scheff, 1966:39-47).

Although residual deviance is highly prevalent in our society, a large proportion of it goes undetected and untreated:¹⁶

There is evidence that gross violations of rules are often not noticed, or, if noticed, rationalized as eccentricity. Apparently, many persons who are extremely withdrawn, or

who 'fly off the handle' for extended periods of time, who imagine fantastic events, or who hear voices or see visions, are not labelled as insane either by themselves or others. Their rule-breaking, rather, is unrecognized, ignored, or rationalized. This pattern of inattention and rationalization (is) called 'denial' (Scheff, 1966:48).¹⁷

Yarrow et al. (1955:12-24) in their research concerning the pre-patient phase of the career of the mental patient, document the great capacity of family members, prior to hospitalization, to overlook, minimize and rationalize evidence of mental illness in one of their intimates. Similarly, Sampson et al. (1962:88-96) found that family members frequently develop elaborate mechanisms of accommodation in order to keep the individual within the family. It is only when a crisis occurs, when the behaviour becomes intolerable that this accommodative pattern is broken and the residual rule-violation no longer remains undetected:

The career of the mental patient and his family ordinarily comes to the attention of treatment personnel during the course of an 'unmanageable' emergency...Prior to this public phase of the crisis, the disturbance of the patient is contained within an interpersonal community setting. It is the collapse of accommodative patterns between the future patient and his interpersonal community which renders the situation unmanageable and ushers in the public phase of the pre-hospital (or rehospitalization) crisis (Sampson et al., 1962:95).¹⁸

While the majority of rule-violations are ignored or rationalized, and thus, are of transitory significance, however, the deviant behaviour becomes visible when the audience reacts toward it. Specifically, when an individual's actions become intolerable, when he can no longer respond accurately to the demands of others in the situation, when a crisis occurs,

family members or official third parties, such as the family physician, police, court officials, or social agencies react to this behaviour and define the individual as 'mentally ill.'

Through the persuasive pressures of these primary and secondary groups, the individual is forced to leave his present setting and move into a psychiatric institution designed to deal with his 'illness.' Sometimes, a person may himself recognize the deviant aspects of his behaviour and voluntarily seek psychiatric help, but more frequently, the individual is hospitalized by others against his will.¹⁹

When the individual becomes hospitalized, he/she initially undergoes a 'psychiatric examination,' or through what is referred to as 'commitment proceedings.' As Scheff (1964:401-413) suggests, these hearings are quite brief in nature. The decision to commit a person to the mental hospital is largely based upon the presumption that he is mentally ill. That is, by virtue of the fact that laypersons on the outside have diagnosed the individual as mentally ill and have taken him to the psychiatric hospital, psychiatric staff presume that he is suffering from some type of mental disorder. Mechanic (1962:66-75), in his discussion of the commitment proceedings at two large mental hospitals writes:

In the two mental hospitals studied over a period of three months, the investigator never observed a case where the psychiatrist advised the patient that he did not need treatment. Rather, all persons who appeared at the hospital were absorbed into the patient population regardless of their ability to function adequately outside the hospital.

Similarly, Kutner (1962:383-399) also reports a strong presumption of

mental illness by staff members:

Certificates are signed as a matter of course by staff physicians after little or no examination...The so-called examinations are made on an assembly-line basis, often being completed in two or three minutes, and never taking more than ten minutes. Although psychiatrists agree that it is practically impossible to determine a person's sanity on the basis of such a short and hurried interview, the doctors recommend confinement in 77% of the cases. It appears in practice that the alleged-mentally-ill is presumed to be insane and bears the burden of proving his sanity in the few minutes allotted to him...

Scheff (1964:410), in his analysis of the motivation behind this presumption of illness states that it is due to the interpretation of current psychiatric dogma by the examiners--specifically, it is thought that: (1) the condition of mentally ill persons will worsen without psychiatric assistance; (2) psychiatric treatment is generally beneficial for the patient; (3) there are no risks involved in involuntary psychiatric treatment: 'it either helps or is neutral, it can't hurt;' (4) patients are potentially dangerous to themselves as well as others; thus, it is better to risk unnecessary hospitalization than to risk harm to self or others.

According to proponents of the social-role model, the individual enters the 'in-patient' phase of his career upon hospitalization. During the first stages of hospitalization, the patient generally feels betrayal by his significant others, agitated boredom and loneliness.²⁰ Upon admission, the patient is stripped of many of the rights and accustomed satisfactions he had on the outside--the patient is forced to undergo various processes which serve to mortify his old identity. The institution offers in its

place a redefinition of self as 'mentally ill.' Although the patient may initially reject this new identity, through the constant reaffirmation of the institutional staff, and sometimes even fellow patients,²¹ the patient is forced to adopt this definition of self. As Scheff (1966:84) notes, patients are rewarded by the staff for adopting the role of mental patient, and punished for failure to do so:

Ordinarily patients who display 'insight' are rewarded by psychiatrists and other personnel. That is, patients who manage to find evidence of 'their illness' in their past and present behavior, confirming the medical and societal diagnosis, receive benefits.

In short, while the patient may not initially accept this redefinition of self as 'deviant,' due to the rewards and punishments accorded him by the institution, coupled with the shared definitions significant others have of him, the patient is forced to accept the definition 'mental patient'-- a generally permanent label and stigma that affects the individual's further participation in society.

Upon release from the mental institution, the patient enters into what advocates of the social-role model refer to as the 'post-patient' phase of his career--a phase generally characterized by stigmatization. Because of the unfavourable definition given to mental illness, discharged patients are stigmatized by society. As Goffman (1963:3) notes:

By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances.

Scheff (1966:87) and Lemert (1951:434-440) contend that ex-patients are blocked from entry into 'normal roles' once this deviant label has been applied to them--they are faced with discrimination in social, marital and occupational spheres. ²² Although society urges the discharged patient to rehabilitate himself and 'make it out in the community,' it actually functions to block his re-entry into old roles, as well as blocking his entry into new 'normal roles.' In short, society forces the individual to retain permanently the label 'mental patient.'

In terms of the strengths of this model, we can credit the social-role approach for focussing on the social processes by which an individual comes to be defined and treated as mentally ill. In contrast to previous models, the social-role model of mental illness centres on the societal reaction aspect to residual rule violations as the major feature in the development of the mentally ill role.

In addition to focussing on those who define an individual as mentally ill, we can also credit the social-role model for centring on the world of the mental patient from his point of view. That is, adopting the perspective of the person adjudged to be mentally ill, proponents of this approach examine how the individual reacts to this designation, and how his self-concept is altered after the deviant label has been affixed to him.

The present research adopts the social-role model in its examination of mental patients and mental institutions. Specifically, this study seeks to examine the three phases in the career of the mental patient:

- (1) the pre-patient phase;
- (2) the in-patient phase;
- (3) the post-patient phase.

Conceiving of mental illness as subjectively problematic, this study will focus on the social definition of mental disorders. Adopting the perspective of those who define an individual as mentally ill, this research will examine the circumstances under which an individual is set apart and considered to be disturbed, how the person is cast into the mentally ill role, and how others act toward the individual after he has been redefined.

Moreover, adopting the perspective of the individual designated as mentally ill, this research will also focus on the person's reactions to this label, how he adopts this new role, and to what extent his self-conception is realigned in accordance with the new role bestowed upon him.

In conclusion, this chapter has presented to the reader a discussion of four major models of insanity, their basic assumptions, proponents of the models, followed by an examination of the strengths and weaknesses of each model. The chapter concluded with a discussion of the model adopted for the present study and an outline of the general areas of exploration in the thesis.

The next section will present a formal analysis of the data. ²³

FOOTNOTES FOR CHAPTER THREE

- 1 See Rosen (1968).
- 2 The reader should note that the framework adopted for this discussion does not represent an absolute, all inclusive classificatory scheme of the models of insanity. Others have classified the various perspectives on mental disorders into different conceptual models. See, for example: Siegler and Osmond's (1974) eight model classification scheme; Schwab and Schwab's (1978) trichotomous cheme; and Townsend's (1978) dichotomous scheme. It is beyond the scope of this discussion to deal with all the models of insanity that have been constructed throughout history. This chapter will focus solely on the major models that have specific relevance to the conceptual model adopted by the present study.
- 3 The processual nature of mental health and illness is elaborated by Offer and Sabshin (1966).
- 4 For a detailed discussion of the clinical universalist stance, see: Kiev (1972); Chauncey (1975); Zung (1969); Ciba Foundation Symposium (1965).
- 5 Social scientists have rejected the medical model of mental illness. See for example: Laing (1965), (1969); Sarbin (1969); Scheff (1966), (1967); (1974); and (1975); Braginsky et al. (1969); Foucault (1976); Erikson (1957). Similarly, clinicians also find this model unsatisfactory. See, for example: Szasz (1957a:599-607), (1957b: 405-413), (1960), (1963), and (1970); Adams (1964:191-197); Balance et al. (1970:133-137); Leifer (1970-71:13-21); Sarason and Ganser (1968: 507-510); Engel (1977:129-136); Carpenter et al. (1977:14-20); Strauss et al. (1977); Begelman (1971:38-58).
- 6 Ethnopsychiatrists have criticized the medical model for its failure to focus on social/cultural factors in the examination of mental illness. See for example: Eaton and Weil (1955); Haywood (ed.) (1970); Favazza and Oman (1977); Foulks et al. (eds.) (1977); Ken-

nedy (1974).

- 7 See, for example, Rosenthal (1961); Kringlen (1969).
- 8 See Laing (1965) for a detailed discussion of this area.
- 9 For a discussion of the social definition of illness in general, see: Parsons (1951a: 428-479).
- 10 It is beyond the scope of this chapter to deal with all the criticisms levelled against Parsons' model of illness. The interested reader may consult the following: Gordon (1966); Freidson (1970); Waitzkin and Waterman (1974).
- 11 For a detailed critique of the medical model from an existentialist perspective, see: Cooper (1967:1-14).
- 12 This term is used by Edgerton (1966).
- 13 This term is used by Murphy (1976).
- 14 This term, employed by Townsend (1978), has been adopted in the present study.
- 15 With reference to the application of labelling theory to the study of mental illness, Scheff (1966), (1967), and (1975) has developed the most systematic statement of this orientation. Partial aspects of this perspective can be found in Szasz (1961), (1970); Lemert (1951), (1967); Goffman (1961); Erikson (1957); (1964) and (1966).

- 16 Lemert (1951) refers to unrecognized or residual rule-breaking as primary deviance. Balint (1957:18) terms this behaviour as 'the unrecognized phase of illness.'
- 17 See also, Hollinghead and Redlich (1958:172-176); Cumming and Cumming (1957:92-103).
- 18 See also, Schwartz (1957:271-291).
- 19 For a discussion of the pathways leading to hospitalization see: Smith and Hall (1963:228-233); Mechanic (1962:66-74); Denzin and Spitzer (1966:265-271); Miller and Schwartz (1966:26-35); Lemert (1962:2-20); Goffman (1959:123-142); Hammer (1963:243-251); Wood et al. (1960:632-641).
- 20 See Goldman et al. (1970:427-434); Goffman (1961).
- 21 See Caudill et al. (1952:314-334); Goffman (1961).
- 22 See for example, Philips (1963:963-973); Whatley (1959:313-320); Cumming and Cumming (1965:135-143); Miller and Dawson (1965:281-287).
- 23 For this study, 'data analysis' refers to: "the process which entails an effort to formally identify themes and to construct hypotheses (ideas) as they are suggested, and an attempt to demonstrate support for those themes and hypotheses." (Bogdan and Taylor, 1975:79); See also Glaser and Strauss (1967).

CHAPTER FOUR

METHODOLOGICAL ORIENTATION

The preceding chapters outline the general areas of concern of this thesis, the theoretical orientation upon which the study is based and the concepts employed, and provide a discussion of the relevant literature on the nature of mental illness. The present chapter focuses on the methodological orientation of this research which seeks to understand the world of the mental patient as he/she experiences it. Specifically, it begins with a discussion of the utilization of participant observation as the major form of data collection, followed by a description of the research settings and sample studied. It discusses how access was obtained into the two research settings and the problems faced when attempting to 'make a bargain.' The chapter concludes with a discussion of the researcher's data collection experiences with the patients.

As outlined earlier, adopting a symbolic interactionist perspective, this research centres on learning about the world of the mental patient from his/her point of view. It will be recalled that the symbolic interactionist perspective argues that in order to understand human behaviour, one must take the role of the other. That is, one must attempt to understand behaviour from the actor's point of view. Understanding, in this perspective, requires being socialized into the groups one wishes to comprehend. Only in

this manner is one able to learn the symbols and referents of the group and come to share in its meanings. The data described in this thesis was gathered through participation with mental patients while attempting to understand their world by sharing in their 'definitions of the situation' (Thomas, 1931:41) and 'constructions of reality' (Berger and Luckmann, 1966).

In order to learn the meanings that the patients define as being important an open theoretical scheme was adopted. As Becker et al. (1961:18) states, it is necessary to 'use methods that would allow us to discover phenomena whose existence we were unaware of at the beginning of the research.' In this present study, the underlying social psychological orientation led to the adoption of a qualitative and inductive methodology, namely participant observation.¹

Schwartz and Schwartz (1955:91) define participant observation as a process in which:

the observer's presence in a social situation is maintained for the purpose of scientific investigation. The observer is in a face-to-face relationship with the observed, and, by participating with them in their natural life setting, he gathers data. Thus, the observer is part of the context being observed, and he both modifies and is influenced by this context. The role of the participant observer may be either formal or informal, concealed or revealed; the observer may spend a great deal or very little time in the research situation; the participant-observer role may be an integral part of the social structure or largely peripheral to it.

Similarly, Florence Kluckhohn, in her classic description of participant observation states that this methodology involves a:

...conscious and systematic sharing, insofar as circumstances permit, in the life activities, and on occasion, in the interests and affects of a group of persons (1940: 331).

In contrast to traditional empiricists who adopt a positivist stance and seek facts or the causes of social phenomena with little interest in the subjective states of the individual actors, the participant observer, adopting a phenomenological perspective, is concerned with 'verstehen' or 'subjective understanding.'² For the participant observer, primary significance is placed upon the interpretation of the actors. Reality is not an entity external to individual knowledge as the empiricists believe; for the phenomenologist, reality is what the actors define to be real. As W. I. Thomas (1928) writes: "If men define situations as real, they are real in their consequences." By taking the role of the other, the researcher shares some of the experiences of the participants under investigation. Through symbolic interpretation, the participant observer comes to understand the symbols and meanings that the actors use to organize their world. Much like cultural anthropologists, the aim of the participant observer is to 'penetrate beneath the veil.'³ Herbert Blumer (1962:188) aptly sums up the role of the participant observer:

To catch the process, the student must take the role of the acting unit whose behavior he is studying. Since interpretation is being made by the acting unit in terms of objects designated and appraised, meanings acquired, and decisions made, the process has to be seen from the standpoint of the acting unit...To try to catch the interpretative process by remaining aloof as a so-called 'objective' observer and refusing to take the role of the acting unit is to risk the worst kind of subjectivism--the objective observer is likely to fill in the process of interpretation with

his own surmises in place of catching the process as it occurs in the experience of the acting unit which uses it.

In sum, the present study is concerned with meaning, with those elements through which mental patients understand, communicate and act within their world. The aim of this research is to grasp the reality of the mental patients as they experience, define and construct it.

As with any methodological approach, there are certain limitations with the methodological approach adopted by this research.⁴ In order to obtain ethnographic data about aspects of the patient's social life, rigorous statistical measures were not employed; rather, than beginning with a priori hypotheses and proceeding to test the relationships between variables in these hypotheses, this study focuses upon the collection of descriptive data on the nature of patient social life.

Description of the Research Settings and the Sample Employed in this Study

The present research is based on approximately one hundred and sixty hours of participant observation conducted on two patient populations in different research settings: (1) from September, 1979 to April, 1980 fieldwork was conducted on institutionalized mental patients at a government psychiatric hospital in Southern Ontario, designated here as 'Springville Psychiatric Hospital;' ⁵ and (2) from January, 1981 to June, 1981 participant observation was conducted on discharged mental patients during weekly therapy sessions in the psychiatry department of a general hospital.

In terms of the former, Springville Asylum was constructed over

a century ago on five hundred acres of farm land situated on the periphery of an urban community. In the early days, the asylum functioned as a self-sufficient community--livestock, poultry, fruits and vegetables were raised on the land with the patients actively taking part in this enterprise. The building complex itself was a four-storey brick structure with heavy mesh screening covering the windows. Patients, segregated on the basis of sex and acuteness of illness were placed in locked wards. The main corridors in the wards were dimly lit; the walls were painted dreary institutional colours. Physical comforts such as draperies, carpets and comfortable furniture were minimal, the emphasis placed on utility rather than beauty. There were only a few heavy oak chairs and benches for the patients to sit upon. Moreover, patient privacy was minimal. Bedrooms designed for one individual, were shared by four patients.

In the early 1960's with the shift in ideology from custodial to therapeutic and humanistic care, the old building was torn down and replaced by a modern facility--an institution with an entirely different character. In contrast to the wards in the old building, the new wards have cheerfully painted walls, draperies, comfortable furniture, numerous lounges, activity areas with televisions, stereos and pool tables. Patient rooms are larger, brighter and have closets to store personal belongings. Generally, while there are four beds in each room, some private rooms are available.

In order to gather data on the world of the institutionalized mental patient, participant observation was conducted on an 'admission ward' in this new psychiatric facility. The ward had a fluctuating patient

population of between twenty to forty patients. In contrast to the old ward system which segregated patients by sex, the admission ward had both males and females, ranging in age from seventeen to mid-seventies. The length of stay on this ward varied from a few weeks to several months, after which they were either discharged or transferred to another ward for further treatment. In terms of the admission status of the patients, the ward contained a mixture of 'first admissions' and 'readmissions,' the majority of which were admitted 'involuntarily.'⁶

Further, in order to gather data on the world of the discharged mental patient, participant observation was also conducted on ex-mental patients during weekly group therapy sessions, arts and crafts sessions and social activities in the psychiatry department of a general hospital. Persons were also interviewed on an individual basis. Specifically, a group of between twenty to forty-five males and females, both young and old were interviewed--individuals who had been institutionalized for varying periods of time and are now living in the community.

Gaining Access Into the Research Settings

This section of the chapter attempts to document the initial stages of the fieldwork experience. Specifically, it focuses on my attempts to make bargains with the gatekeepers⁷ of two powerful institutions, namely the professional staff of a large psychiatric hospital, and the staff of a general hospital respectively.

When field researchers conceive of the 'bargaining stage' of research, we often think of it as a rather static phase. The underlying tenet is that the researcher is able to enter a setting, make a bargain, develop rapport with his respondents and no further negotiation is necessary. My fieldwork experience (similar to others)⁸ reveals that the bargaining stage is actually a continuous process--negotiation and renegotiation continues throughout the research endeavour. As Haas and Shaffir (1980:245) aptly point out:

* What is referred to as the 'bargain stage' of research is more accurately conceptualized as a series of negotiations throughout the research endeavour wherein the researcher continually attempts to secure others' cooperation. Bargain negotiations typically require the development of relationships of equality, involving an idea of exchange, or 'give and take.' This is particularly true in cooperative relationships between professionals.

Examination of the series of negotiations and renegotiations between the gatekeepers and myself reveals that both parties were struggling for superiority. Each party sought to gain control of the situation.

As Becker (1964:272) notes, an irreconcilable dichotomy exists between the interests of the researcher and the individuals representing the institution under investigation. Every institution, when under examination seeks to control the outsiders' study of their behaviour. The institution wants to ensure that the results of the study are consonant with its official ideology, hence allowing the organization to remain in a positive light.

I met several problems when attempting to make a bargain with a large, government psychiatric hospital. My interest in studying the institutionalization of mental patients from their point of view was responded to by the gatekeepers in an extremely negative and wary manner.

In order to receive permission to conduct this research, an initial series of meetings occurred between an administrative official in charge of the educational services of the institution and myself. During the first meeting, I introduced myself and outlined my research interests in a general manner:⁹

I'm a fourth year sociology student. As part of our qualitative methods course, each student is required to conduct a study of a social group...I am particularly interested in studying mental patients from a subjective point of view... (Interview #1, October 3, 1979:9).¹⁰

I continued to explain that the study would be strictly confidential in terms of both the identity of the hospital and the patients involved. Moreover, the research would be unobtrusive in nature. At no time would the fieldwork interfere with the formal treatment activities of the patients. It was also stressed that the study would be non-evaluative in nature. My aim as a sociologist was not to evaluate the treatment programmes or the general conditions of the hospital; rather, the aim of the proposed study would seek to understand the social world of the mental patient as he subjectively experiences it.

Subsequent to this initial meeting a detailed research proposal was requested and submitted to the gatekeeper providing a description of

the aims, the theoretical and methodological orientation and anticipated significance of the study. This official objected to the proposed project on several grounds:

(1) the study was too 'broad' and 'vague.' The project lacked rigorous design--it did not possess specific hypotheses that could be empirically tested;

(2) the proposed study was not valid. It was felt that the study possessed no validity because it was not examining the biological and genetic factors affecting mental illness;

(3) the unobtrusiveness of the research was questioned--the gatekeeper felt that the patients' rights would be violated by such an investigation. The study would undoubtedly be disruptive for the patients;

(4) the safety of the researcher was a major issue--it was conceived that I might be seriously injured if allowed to conduct research on a psychiatric ward;

(5) the gatekeeper suggested that the ward staff might object to my presence on the ward;

(6) finally, the gatekeeper felt that the research lacked significance for the hospital--the hospital would not benefit in any form from a 'sociological' study (Interview #1, October 3, 1979: 11-16).

Although I had expected that my proposal would be critically examined, I did not anticipate the number of obstacles that were placed in front of me. I had no idea that an institution which is an 'accredited teaching hospital' would be so unsympathetic to alternative types of research involving mental patients. From the outset of the negotiations, very little attempt on the part of the gatekeeper was made to understand the sociological significance of the proposed project. The inductive nature of the research was viewed by the gatekeeper not as a methodological orientation within which one gathers descriptive data on human behaviour; rather, it was interpreted as a lack of knowledge about the nature of mental illness on the part of the researcher. In order to clarify my perspective, I repeatedly emphasized the theoretical and methodological orientation of the research and stressed why it is of utmost importance to begin the study with no preconceived hypotheses in mind. But to professionals schooled in the natural sciences who approach the study of phenomena from a positivist stance, my proposal seemed 'too vague' and meaningless.

A second major objection to the research proposal centred on the validity of the study. Specifically, it was felt (by two ward psychiatrists and an administrative official) that my study was invalid because "mental illness or the process of mental illness (was) not being considered." The administrative gatekeeper emphasized that the proposed study lacked validity because it did not focus upon the biological or genetic bases of mental illness. Adopting the medical model of mental illness, the gatekeepers flatly rejected the social-role model of men-

tal illness--the model upon which the proposed study was based. In response to this objection, I argued that while the medical model may have some credibility in terms of explaining the nature of mental illness, it is of equal importance to examine the nature of mental illness from a sociological perspective.

Regarding the issue of patient rights, it was repeatedly stressed by the gatekeeper that my participant observation would undoubtedly upset the patients. Conceiving of sociologists in a negative manner, the gatekeeper told me at one of our initial meetings:

All they (sociologists) do is come in and disturb everyone... From my experiences with anthropologists and sociologists, all they do is get everyone upset. Even clergymen coming in, when they try to talk religion to the patients they just upset them because they (the patients) end up having religious delusions... If you were qualified and experienced with the patients, I might let you in but I'm afraid you would only upset them (Interview #1, October 3, 1979:12).

I assured the gatekeeper that my presence would not upset the patients. I would only converse with the patients if they so desired. We would talk about subjects that they defined as being important. No attempt would be made to pry into areas they did not wish to discuss.

Another major objection to the proposed study concerned my own safety. Throughout our negotiations it was repeatedly expressed that this study would be potentially 'dangerous' to me. Every attempt was made to point out to me that 'there are three hundred psychotic patients in this hospital.' I felt that the gatekeeper was employing a scare tactic in the hope that I would become apprehensive about conducting the study.

However, I assured the gatekeeper that I was not afraid to conduct fieldwork in this setting. Moreover, if the hospital was worried about the legal obligations of my safety, I would agree to sign a statement releasing the institution of any liabilities.

Regarding the problem of the anticipated objection of the ward staff, I offered to speak with both the ward supervisor and ward psychiatrist outlining the aims of the project.

One final objection recurred throughout the negotiation process related to the anticipated significance of the proposed study. Specifically, the official gatekeepers repeatedly asked: "What will the hospital get out of this study?" "There doesn't seem to be anything in it for us." ¹¹ In response, I argued that the anticipated significance of the study was threefold: it has significance for sociologists, social psychologists, psychiatrists and all who are interested in obtaining a fuller understanding of social problems of which mental patients are a part. Secondly, this study has practical significance in that certain processes which may come to light as a result of this fieldwork may be taken to a higher level of abstraction and utilized to understand other social groups. Finally, through this study both the researcher and the hospital will gain an understanding of the processes and consequences of institutionalization upon the self-images and identities of mental patients.

The initial series of negotiations, prior to the commencement of field research, lasted approximately one month, with the researcher formulating and reformulating research proposals in an attempt to clarify and 'sell' the proposed study. During this time, a meeting was held with

the ward supervisor, ward psychiatrist and myself in which the theoretical and methodological orientation of the study was discussed. Similar to my earlier meetings with the administrative gatekeeper, these gatekeepers reacted to the study in much the same manner. Two things were suggested to me: (1) that I "go home and rethink the project and come back some other time." or (2) that maybe I should go and study some other group outside this institution such as an ex-mental patient group in the community.¹² Despite the procrastinations, I did not discourage. After presenting the administrative gatekeeper with an extensive, revised research proposal providing solutions to each objection raised, a bargain was finally made. However, still in one final attempt for the institution to control the situation, the gatekeeper suggested that he be given access to my fieldnotes in order to 'give direction' to my research.

....I think that you will need some guidance. You know Nancy, you could easily get lost in this institution. I don't mean physically, but you could be out there (he points to the air) trying to collect data but in the process you get lost in the shuffle. I think that I should be your advisor. You should report to me once a month with your notes so that I can direct your research. If you are going down a wrong path, I can set you straight. (Interview #5, October 15, 1979:6).

In response to the gatekeeper's request for access to my fieldnotes I emphasized that as an ethical researcher I had an obligation to protect the patients under investigation. Under no circumstances would the gatekeeper be allowed to examine my fieldnotes--they were strictly confidential and would remain the sole property of the researcher. I expressed

the point of view that sharing the fieldnotes would be a violation of the researcher's code of ethics, specifically protecting patient confidences and anonymity. Through the 'give and take' process researchers and gatekeepers engage in when bargaining it was finally agreed that the fieldnotes would remain the property of the researcher, but I would meet with the gatekeeper on a regular basis to discuss my research in a general manner.¹³

After this arduous series of negotiations during which both parties continually struggled for superiority a bargain was achieved. I finally began to conduct fieldwork on the ward. Although I thought that negotiations had been completed at this point, this was far from being the case for two and a half weeks later I was notified by the administrative gatekeeper that a meeting was scheduled to 'discuss my proposal'--this time the meeting would involve the ward supervisor, ward psychiatrist, administrative official, my advisor from the university, and myself. Further, I was also informed that I was suspended from conducting fieldwork until after this meeting. During this meeting, we once again discussed the theoretical underpinnings of the proposed study and the methodology. Addressing my advisor, one of the gatekeepers expressed his central concerns and reservations about the study:

In our previous discussion with Nancy, I expressed concern with her study on the grounds that it was abstract and possessed certain contradictions. I find it difficult to deal with this notion of 'understanding'.....(Interview # 10, November 13, 1979:3).

The gatekeeper felt that one could not get at an understanding of what it is like to be a mental patient from the type of study proposed. He argued that the study would just be detailing what a 'researcher thinks it is like to be a patient.' Moreover, the gatekeeper stated that this study could not help but be evaluative in nature--the researcher would not be objective. In response to these areas of concern, my advisor argued that our aim as social scientists is to understand. We were not interested in evaluating the conditions of the setting or the treatment approaches. He explained that we were not journalists interested in publishing our findings in popular magazines or newspapers. We instead were scientists, attempting to understand social phenomena. He further pointed out that we were interested in examining social processes; my study would be an attempt to examine the processes of institutionalization and its effects on patient self-images. The study would be an attempt to look at reality in terms of what the patient, individually and/or collectively, define as important and real.

However, the gatekeepers (particularly the ward supervisor and ward psychiatrist) still viewed my study in a negative manner. My advisor asked the gatekeepers if they had ever read any sociological studies which adopt an interactionist perspective. As was anticipated, they had not. As a result, I handed the gatekeepers a book of readings that adopted this theoretical stance along with a brief introduction to symbolic interactionism. In a rather reserved tone, one of the gatekeepers replied:

Well, I will have to examine these ideas further. Maybe through further reading, I will come to grips with this...
(Interview #19, November 13, 1979:4).

A second gatekeeper concern centred on the learning objectives discussed in the proposal--the same proposal which was agreed to by the administrative gatekeeper two weeks prior to this meeting. Once again, the gatekeepers wanted to know how the 'hospital would benefit' from the study. I described the theoretical and practical significance of the project pointing out that both the hospital and myself would undoubtedly learn about the processes and consequences of institutionalization upon the patient's self-concept. Because of the institution's interest in 'getting something out of this research,' I offered to give a seminar to the ward staff upon completion of the study, outlining my findings in a general manner. This offer was responded to by the gatekeepers in a favourable way.

A third concern was expressed concerning my role on the ward. One of the gatekeepers stated that the ward staff were confused about my identity and the objectives of my study:¹⁴

The staff are confused about your role, what it is that you're doing here. You have to realize that you're different, Nancy. You are not the conventional student coming onto the ward. We usually have nursing students, medical students who have specific objectives to meet...We have a very regimented structure here...Your proposal is very different (Interview #10, November 13, 1979:6).

In response to this area of concern, I stated that, in violation of our original agreement in which both the administrative gatekeeper and the ward supervisor agreed to inform the staff about my presence and the aims of the study, nevertheless, they were confused about my role; hence, I

was being treated very coldly by the staff. Essentially, the staff thought I was conducting an evaluative study of them, despite my efforts to explain what I was actually doing. And this placed me in a precarious position--I was afraid that my interacting with the staff would seriously harm my rapport with the patients. It was agreed by the gatekeepers that this situation would be cleared up immediately--one of the gatekeepers would personally ensure that every staff member was informed. (Unfortunately, this promise was not carried through for throughout the entire fieldwork experience, I was continually faced with individuals for which I had to explain my role and objectives).¹⁵

One final concern was expressed by one gatekeeper, specifically related to the problem of 'transference.' The gatekeeper stated that he had reservations about the manner in which data would be collected--it was felt that, conducting a study from a subjective point of view, participating with the patients and coming to an empathetic understanding, would undoubtedly result in myself 'going native'¹⁶ or associating myself with the patients. I assured the gatekeeper that this would not happen; while the participant observer actively participates in the lives of his informants, at the same time he has the capacity to remain detached and objective.¹⁷

After long deliberation, I was once again granted access into the hospital. Walking out the door, I remarked to my advisor that I never thought that the bargaining stage would continue throughout the research endeavour. One of the gatekeepers, overhearing this statement replied in a half-joking manner:

This is only the beginning Nancy. I told you this wasn't going to be easy (he chuckles). You ain't seen nothin' yet! (Interview #10, November 13, 1979:8).

Ignoring this warning, I assured myself that I was finally allowed access into the research setting--the bargain had been made for good. I was sure that no further negotiation would be necessary between the gatekeepers and myself, but I was wrong.

Trouble loomed once more about two months after this second bargain was made. I was informed by the administrative gatekeeper's assistant that she had received an alarming phonecall from an anonymous source regarding my research:

Nancy, I had this call yesterday from an hysterical woman who was saying some disturbing things...This woman said that your reports (fieldnotes) were being given out to the thirty people in your class and that they were also available to anyone else who wanted them. She told us that these reports were derogatory to the hospital--they stated that there were all kinds of suicides and escapes going on that no one knows about...This woman expressed that she didn't want to phone us but her conscience was bothering her and she waidd that we have to stop you (Interview #14, November 27, 1979:1).

I was shocked when I learned of this news. In response to these allegations, I emphasized to the gatekeeper that the notes were not being distributed to 'any one who wanted them.' The only individuals allowed to see my fieldnotes were my professor, myself and my fellow classmates who had taken an oath of confidentiality. I pointed out that at present I had no reason to believe that anyone had violated this oath. I stressed that:

We can't deal with hearsay evidence here. My fieldnotes are not an attempt to damage the hospital in any way...I am not interested in conducting an exposé of the hospital. I think that this phonecall represents an effort to damage myself, rather than to damage the hospital (Interview #14, November 27, 1979:1).

The gatekeeper agreed with this point but emphasized that because the anonymous phoner caller specifically identified my name and the research class I was in, this phonecall could not be disregarded. The gatekeeper's assistant wondered if the phoner caller was one of the patients that I was interviewing who "became upset with my questioning." But because the caller gave my full name, knew details about the qualitative methods course in which I was enrolled, and asked for the administrative official with whom I was bargaining, the gatekeeper's assistant felt (as I did) that this person was probably someone from my class who was attempting to sabotage the research. Nevertheless, the institution could not ignore this phonecall--this call indicated that their identity was being threatened. In response to this call, the institution made a serious, forceful attempt to gain control of the situation.

Specifically, it was suggested that I discontinue my fieldwork until a meeting could be set up between the administrative gatekeeper and myself at which time a decision would be reached regarding if the project should be allowed to continue. I argued that it would be impossible for me to stop conducting fieldwork at this time because it would seriously affect the rapport I had established with my subjects. Reluctantly, the gatekeeper's assistant allowed me to continue the study in the interim.

In the following week, I met with the administrative official one more time. During our earlier negotiations, an attempt was made on the part of the gatekeeper to establish a somewhat collegial relationship with me; however, from this meeting onward, a gradual breakdown in collegiality and cooperation developed. The gatekeeper responded to my research in an extremely negative manner. In an attempt to convince the gatekeeper that the allegations made against my research were simply not true, I stated:

You know, I am just as upset about this incident as you are Mr. _____. My professor and I have questioned the credibility of this phonecall on several grounds. First of all, this call was said to have been made by a 'doctor's wife.' If so, why did she refuse to identify herself? It seems to me that anyone who is willing to give such information would not be afraid to give her name, unless these accusations were false...this woman claimed that my reports were being circulated throughout the university--this is not true. Only the people in my class were allowed to see these notes and my professor swore them to confidentiality. In terms of the content of the notes, no where was there anything written that was meant to be degrading to the hospital. (Interview # 16, December 4, 1979:3).

I explained to him that careful examination of this unfortunate incident indicated that someone in my class deliberately set out to undermine my fieldwork. I was aware that some of my fellow classmates were jealous of my research and earnest efforts and even made threats that they were going to sabotage the study, but I never thought that they would follow through on their threats. I emphasized to the gatekeeper that:

...this call was merely aimed at getting me into trouble. What I'm trying to say is that you can't see this incident as an effort to damage the hospital, but rather, it repre-

sents a blatant effort to damage myself and my professor; we are clearly the victims here! (Interview #16, December 4, 1979:4).

The gatekeeper was not convinced by this explanation and offered an alternative interpretation of the incident:

This is all very interesting, I mean, this idea that people in your class made this phonecall, but I have a different perception of this incident. I think that your advisor and you are missing the point. You are attempting to rationalize the irrational. I think that this is one of the downfalls of sociology. My perception of all this is that if a person is doing this to you in class, he/she must be mentally ill. Perhaps the way in which you are discussing the topic of mental illness in your notes is upsetting this person. I try to listen to what the irrational is saying to me. I see this incident as an irrational person's way of crying for help. They do this by phoning the hospital. Obviously, there is something in your fieldnotes that is wrong; you are probably missing talking about what constitutes mental illness....I'm not interested about who in your class did this. What is important is this 'message' and I'm going to have to follow it. When I get messages like this, they are usually telling me something important (Interview #16, December 4, 1979:4).

To ensure strictest confidentiality, I informed the gatekeeper that, from this point on, no one would receive further fieldnotes. I would only discuss my research with my advisor.

The gatekeeper in another effort to gain control over the research requested that he be given access to my fieldnotes. I flatly denied this request on the basis of an ethical obligation to protect my subjects. Realizing that I possessed this strong conviction to protect my informants, the gatekeeper reluctantly changed the subject. He

He handed me a counter-proposal written by two psychiatrists who had critiqued my original research proposal--the same proposal to which one of the two psychiatrists had agreed two months earlier. This counter-proposal presented a critique of my entire theoretical and methodological framework. Specifically, the psychiatrists expressed two central concerns: (1) they felt that the study would undoubtedly be evaluative in nature. It was expressed that "participant observation studies are affected by the biases of the investigator more than other kinds of studies and the 'facts' emerging from such a study could be merely affirmation of the biases." (November 27, 1979:1). (2) they felt that the study was invalid because it was not looking at the subject of mental illness. As a result of these concerns, it was requested that I only conduct fieldwork during recreational and self-care activities. I was no longer granted permission to conduct participant observation during formal therapy sessions --a violation of one of the conditions of our original bargain. Having no choice in the matter but to abide by the gatekeeper's request, I agreed to this alteration of our original agreement.

Examination of this entire bargaining experience from an interactionist perspective reveals that the institution attempted to 'discourage' me from conducting this research from the outset; however, through persistence, I was reluctantly granted access. Throughout our negotiations and renegotiations, the institution's representatives struggled to gain control over the situation--especially in this latter attempt to gain control of the researcher's fieldnotes. While I managed to successfully resist, the institution did not concede. Although the institution was not able to con-

trol reality in terms of exerting control over the nature of the data being collected, its representatives still managed to control me 'spatially'--that is, they attempted to control the areas and activities which I was allowed to observe.

From a labelling perspective, this bargaining experience can be conceptualized as an on-going struggle of the researcher against being negatively labelled by the gatekeepers of the psychiatric institution. Specifically, the gatekeepers equated the inductive nature of the research with a lack of knowledge on the part of the researcher, thereby attempting to label me as an 'incompetent researcher.' Moreover, possessing the misconceptions that sociologists conduct 'exposé-types' of research, and that the researcher was going to conduct such a study that present the hospital in a negative light, these gatekeepers attempted to attach to me the label, 'troublemaker.' Through my persistent efforts, I attempted to prove my competence as a qualitative researcher by justifying the methodological orientation of the study. I emphasized the non-evaluative nature of the study--I was not interested in 'exposing the conditions or treatment facilities of the institution.' While my efforts partially convinced the gatekeepers of the clarity and rigor of the research design, thereby somewhat dispelling their image of me as an 'incompetent researcher,' nevertheless, they still conceived of me as a 'troublemaker.' As a result, the gatekeepers attempted to control when and where I was allowed to conduct my participant observation.

During subsequent weeks, I conducted fieldwork as many times as possible. I sensed that the hospital was attempting to do something in

order to terminate this research. I was correct, for I received by mail a new research proposal (written by the hospital) detailing an entirely new set of conditions to which I was advised to agree. No attempt was made to explain why such a new proposal was developed. A note was attached to this proposal stating that both my advisor and myself were to sign this agreement and return it immediately. What it would be too lengthy to discuss this new proposal in its entirety, suffice it is to say that the new additional conditions were simply unacceptable—I was being further restricted in the hospital setting which would make it extremely difficult, if not impossible, to achieve the aims of my research. The document stated that from this point on I was to call the ward to arrange a weekly schedule with the ward supervisor when it would be 'convenient for the ward to have me.'

Moreover, this new proposal stated that, "all records (field-notes) will be viewed as the property of Springville Psychiatric Hospital and will be treated with respect and discretion"—a condition that I could not agree to under any circumstances.

Further, in another effort to hamper the research process, they drafted a statement downgrading my capabilities and the quality of the research:

The image of the hospital will be maintained and any discussion that fails to emphasize the strengths of the hospital or tends toward sensationalism will be avoided.

A final condition of the proposal stressed that the paper resulting from this fieldwork would not be published. Under the conditions

of our original bargain, it was agreed that while my immediate aim was not to publish this study, however at some later date should I decide to do so, I would allow the hospital pre-publication criticism rights.

In response to this new proposal, I formulated a letter criticizing every element that was unacceptable. I stressed the fact that the institution reneged on our original bargain and attempted a formal fait accompli which represented a serious breach of professional ethics. I emphasized that such a unilateral power play was offensive to both my advisor and myself. I pointed out that I tried to cooperate with the hospital submitting numerous research proposals and that I was subsequently granted access and 'cooperation' from the institution. The letter was concluded by stating that this set of violations of the original agreement and the attachment of a new set of conditions reflected "unprofessional and unethical conduct unbecoming of representatives of an academically-affiliated institution."

Upon receipt of my letter, the administrative gatekeeper suggested that another meeting take place--this time among the gatekeeper, my advisor, myself and the medical director of the institution. I was emphatically told that:

This is not meant to sound like a threat...but we have to get this letter of agreement signed (the hospital's new proposal) or we'll be forced to terminate your placement! (Interview #32, March 4, 1980:2).

The institution was asserting its authority--its representatives were no longer interested in negotiating. They issued an ultimatum: either

I would agree to the conditions outlined in the new proposal or be forced to leave the setting. I received this ultimatum after seven months in the field during which time I managed to collect a wealth of information regarding the institutionalization of mental patients. Thus, it would not seriously affect the research if the fieldwork was terminated at this point. After discussing the situation with my advisor, it was mutually agreed upon that the best strategy would be for me to leave the field. I phoned the administrative gatekeeper and informed him that my fieldwork was now complete and therefore it was not necessary to have another meeting. In response, he argued:

Well, I think that there is a reason for this meeting... There are so many things that need to be cleared up at this meeting... We have to clear things up regarding publication. Nancy, you may think that you've finished, but we have to get a letter of agreement saying that you won't publish. Right now, we have no control over you and I don't like that... (Interview #33, March 26, 1980:1).

This was a final attempt on the part of the institution to gain control over the situation. I stressed that according to our original bargain it was stated that my immediate aim was not to publish; however, if I should decide to do so, I would allow the hospital pre-publication criticism rights. I emphasized that I had cooperated with the hospital at all times. I had fulfilled every obligation of our original bargain. My fieldwork was now completed; therefore, I saw no reason for further negotiations. I thanked the gatekeeper and said goodbye.

In summary, the preceding discussion focussed on my negotiations

and renegotiations with 'powerful people' in a 'powerful institution.'¹⁸ From an interactionist perspective, it represents the continuous struggle between the researcher and the gatekeepers, each party attempting to gain control over constructions of reality and definitions of the situation. From a labelling perspective, it represents an on-going struggle of the researcher against being negatively-labelled by the gatekeepers as an 'incompetent researcher,' a 'troublemaker' who through her research would undoubtedly destroy the positive image of the hospital.

This bargaining experience lends support to the view that the research bargain is more accurately conceptualized as a continual process that occurs throughout the entire research endeavour (see also, Haas and Shaffir, 1980:245). While this long series of negotiations and renegotiations was sometimes discouraging and anxiety provoking for the researcher, in retrospect, this experience was highly instructive about the problematics of negotiations with 'powerful people' in 'powerful institutions.'

In contrast to the difficulties experienced in making a bargain with gatekeepers of a psychiatric hospital and the extended period of time during which negotiations and renegotiations occurred, I was granted relatively easy access into the second research setting, the psychiatric department of a general hospital.

Specifically, during an initial telephone conversation between a psychiatrist gatekeeper and myself, I identified myself and explained that I was in the process of conducting research on the processes and consequences of institutionalization upon the self-images of mental patients. I pointed out that I had collected data on institutionalized patients, and at present

was interested in gathering data on discharged mental patients:

I'm a graduate student in Sociology at McMaster. Over the past year, I have been conducting a study on the processes and effects of institutionalization on the identities of mental patients. Up to this point, I have been focussing on hospitalized mental patients; in order to make my study complete, I need to gather additional data on ex-patients who are back in the community (Interview #35, October 27, 1980:2).

The psychiatrist responded to my research in a positive manner and suggested that we meet to discuss the project in detail.

During this meeting, I discussed the objectives and methodology of the research--I emphasized that the study would be unobtrusive and non-evaluative and I would ensure the confidentiality of the ex-patients. The psychiatrist approved of the study but indicated that the staff in the department of psychiatry would also have to approve of this research prior to its commencement. He felt that it would not be necessary to negotiate a bargain with the Ethics Committee of the hospital; rather, it would be sufficient to submit a research proposal to the psychiatry department for their approval.

However, approximately two weeks after submitting this proposal, I received a telephone call from the psychiatrist informing me that my research proposal had been discussed at a staff meeting during which time it was pointed out that I must gain approval of the Ethics Committee prior to beginning the study. Apologizing for the bureaucratic red-tape of the institution, the psychiatrist said:

Well, I'm afraid that you're in for some time-consuming activities. You'll have to appear in front of the Ethics Committee to answer their various questions, and you must submit to them a copy of your research proposal. The problem is that the committee only meets once a month, so you will be delayed in beginning your study. I realize that this is an inconvenience since you are on a time schedule (Interview #37, November 12, 1980:1).

He stated that he would send me an application form for permission to conduct fieldwork which I was supposed to submit, along with a copy of the research proposal to the Director of Medical Services of the hospital. The psychiatrist also offered to send a letter to the Ethics Committee stating his full approval of the project.

Approximately three weeks after submitting the form and the proposal, I was granted an interview by the Ethics Committee. During this brief meeting, I outlined the areas of concern of the study, its methodology and anticipated significance. I expressed that I wanted to conduct participant observation in weekly group therapy sessions as well as interviewing individuals on a one-to-one basis. I also emphasized that patients would be selected on a voluntary basis and would be informed of the full aims of the study. The resulting data would be collated without patient names. After finishing my spiel, a member of the Ethics Committee raised one central concern: she felt that I should have patients sign a consent form prior to interviewing them on an individual basis--a recommendation to which I agreed. With no further questions asked or concerns raised, the chairperson of the Committee thanked me for coming and indicated that I would be notified of the Committee's decision regarding the approval of the project.

Three weeks after this meeting, I received in the mail a carbon copy of a letter addressed to the psychiatrist with whom I initially discussed my research, indicating that "the project was considered by the Research Committee at their December meeting....(and) recommended that this project be approved following (the psychiatrist's) approval for the same." The letter further indicated that, prior to my proceeding, it was necessary to send to the Director of Medical Services a copy of the consent form I was going to use. Upon receipt of this letter, the psychiatrist sent a letter to the Committee issuing his full approval of the research. I subsequently sent a copy of the consent form that I was going to utilize. Having sent both these items to the Ethics Committee, a bargain was finally achieved.¹⁹

Learning the Ropes--Researcher Data-Collection Experiences with the Subjects

One of the major goals of the researcher is to become a well-socialized member of the group he wishes to understand. Only by taking the role of the other will the researcher come to comprehend the behaviour of the social group under investigation. In this section of the chapter, I will discuss my data-collection experiences with the patients, specifically focussing on some of the fears and problems encountered during my first days in the field²⁰ and how I managed to 'learn the ropes.'²¹

As Sanders (1980:168) notes, learning the ropes of fieldwork results when the researcher: (1) possesses an understanding of the physical and social structures of the setting and the activities occurring within that setting; (2) feels comfortable interacting with the subjects;

(3) acquires the ability to use the group's language; and (4) possesses the ability to know when his subjects are lying, being facetious or attempting to mislead him.

Examination of the literature written on qualitative methodology reveals that frequently little reference is given to the data-collection stage of research. Because of this neglect, one is often led to believe that learning the ropes is either a process occurring prior to the commencement of the 'real fieldwork,' or is a process occurring simultaneously with the 'real fieldwork.' However, as Kleinman (1980:171) correctly emphasizes, "learning the ropes of fieldwork is not only coincident with doing the 'real work' of field research...but also a part of that process." There is analytical value in examining how a group responds toward the investigator; conversely, it is important to examine the researcher's feelings toward his subjects. During the initial stages of fieldwork, researchers may experience feelings of self-consciousness, discomfort or threat--important data for it allows the researcher to remain aware of his preconceptions, biases and subsequent role alterations as he begins to learn the ropes. In short then, learning the ropes is an integral part of the researcher's analysis of field data.

Fieldworkers learn the ropes by actively participating in the lives of their subjects, by observing, conversing with them, participating in various activities--a process termed as 'hanging around.'²² During the twelve months of research, I participated in and observed as many activities of hospitalized mental patients and discharged patients as possible. I attended various group therapy sessions, participated in special social functions, such as in-patient dances and parties. I also joined hospital-

ized subjects during their leisure time at the patient canteen. I participated in various patient leisure activities such as listening to the stereo, watching television, playing pool, etc.

During the first days of 'hanging around' the researcher often feels uncomfortable and anxious. As Geer (1967:383) notes, these feelings result more frequently from preconceived ideas rather than actual problems:

We do it on each new study. We underestimate people's trust in our neutrality, their lack of interest...And we project theoretical problems into the field. Because the process of group formation is difficult to conceptualize, we suppose it will be difficult to observe. We expect ephemeral, unstructured situations...to appear incoherent.

I felt anxious and uneasy during my initial days of fieldwork. My anxieties were derived from two central concerns: (1) the anticipated fear²³ of being rejected; and (2) intense self-consciousness in the field.

In terms of the former, I imagined that the patients would not welcome my study—they would not want to 'open up' and discuss private experiences in their lives with a stranger. As Sanders (1980:16) correctly notes, we are socialized into thinking that it is illegitimate to violate others' norms of privacy. By so doing, we risk being rejected. Being reluctant to violate the patients' privacy for fear of rejection, I initially entered the role of a passive researcher. I did not ask ask personal or probing questions. Conversations were kept at a superficial level. However, as I gradually became more comfortable with my informants (and they with me), I overcame this imagined fear. I found that the patients welcomed my questioning—they were willing to share

personal details of their lives with a researcher who listened and sympathized with them. As one patient told me:

It's really nice to talk to you--you listen to us--you take us seriously--no one else listens to us around here. (Interview #7, October 25, 1979:3).

In terms of the second problem of self-consciousness, researchers initially feel self-conscious when entering a new and unfamiliar social setting.²⁴ During my first day in the field, I felt as if everyone was watching and evaluating my behaviour. I felt embarrassed when I asked a 'stupid question.' However, I found that the patients did not make light of my ignorance; rather, they attempted to teach me what I did not^o know. Through interaction with the subjects and the development of rapport, I soon overcame this feeling of self-consciousness.

Explanations of My Study and Role as a Researcher to the Patients and their Responses

Prior to beginning a study, the researcher, guided by ethical considerations must decide whether to engage in overt or covert research. While some researchers²⁵ support covert research, the majority of investigators²⁶ oppose it.

Rejecting concealed research in which the aims of the study are unknown to the subjects and the investigator is taken to be someone else (usually one of the subjects), at no time did I pose as a patient;²⁷ neither did I pose as a staff.²⁸ I fully informed the patients and the staff of my

role as a researcher and the objectives of the study. During my initial meetings with the patients, I stated:

My name is Nancy. I'm a sociology student from McMaster University. As part of a course requirement, I'm here doing a study on what it is like to be a mental patient. I'll be coming to visit you for a few hours each week to talk about whatever you want--things you think are important for me to know (Interview #8, October 28, 1979).

I emphasized to the patients that whatever information was told to me would be kept in strictest confidence. I assured the patients, who feared reproachment and punishment from the staff, that all our conversations would remain confidential. Upon making these conditions of my research explicit, I soon developed rapport with the patients and gained their trust.

From the outset, the patients responded to my research in a positive manner. Much to my surprise, they were extremely open about private experiences in their lives. They enjoyed having a sympathetic person listen to them, a person who took their problems seriously. During my weekly visits to the hospitalized mental patients, the participants would eagerly await my arrival, standing at the front door. When I arrived, the patients would frequently argue among themselves regarding who would be first to talk about their experiences with me.

In addition to talking about their own lives, the respondents were interested in learning about my identity. I anticipated that they would ask me numerous questions about my research, but in contrast, they concentrated their questions on aspects of my identity, such as my background, academic

interests, personal likes and dislikes--questions which I readily answered.²⁹

By being open with the subjects and 'giving information' and not solely 'taking it' from them, both parties got to know each other and learned to feel comfortable in each other's company.

In summary, by working hard, by respecting the subjects and taking their views seriously, the patients responded by teaching me the ropes--I achieved a subjective appreciation of the world of the mental patient--an appreciation that could not have been achieved by another methodology.

FOOTNOTES FOR CHAPTER FOUR

- 1 For a discussion of the methodology of participant observation and qualitative methodology in general, see: Cicourel (1964); Bruyn (1966); Bogdan and Taylor (1975); Babchuck (1962:225-228); Adams and Preiss (eds.), (1960); Vidach (1955:354-360); Filstead (1970).
- 2 For a detailed comparison of the traditional empiricist and phenomenological perspectives, see: Bruyn (1966); Bierstedt (1949:584-592).
- 3 This phase was coined by the anthropologist Franz Boas who argued that one must understand a culture from the subjective point of view of the natives themselves without imposing the researcher's Western framework of rationality.
- 4 For a discussion of the limitations of this methodology, see: Dean (1967); Becker (1958:652-660).
- 5 In order to protect the identity of the hospital, a pseudonym has been employed.
- 6 At this hospital, the patients were either classified as 'voluntary' or 'involuntary.' The former status refers to patients who admitted themselves into the hospital on a voluntary basis. These patients were allowed to discharge themselves when they no longer felt like being hospitalized. The latter status refers to patients, who through court orders or psychiatric diagnosis at a general hospital, were admitted into this psychiatric facility. That is, these patients have no choice in the matter--they are admitted on the basis of someone else's judgment that they are in need of psychiatric care. Involuntary patients are discharged at the discretion of the ward psychiatrist and other staff members.

- 7 For a discussion on making bargains with gatekeepers see: Bogdan and Taylor (1975:30-32); Becker (1970).
- 8 See for example, Haas and Shaffir (1980:244-255); and Geer (1970:81-96).
- 9 Bogdan and Taylor (1975:34) suggest that it is the best strategy to outline the study in general terms. "Observers needs not explain their substantive or theoretical interests or their specific techniques in great detail. In fact, it is probably unwise for researchers to volunteer elaborate details concerning the precision with which notes will be taken."
- 10 This, and all subsequent quotations were taken from the researcher's fieldnotes of informal interaction with the staff and patients and were transcribed as nearly verbatim as possible. The names have been changed to protect the identities of the subjects.
- 11 Gatekeepers often ask how they (the institution) will benefit from the research project. This question was repeatedly asked of me during my negotiations and renegotiations with the gatekeepers. Researchers (both anthropologists and sociologists) are often criticized for going into the field, collecting data on aspects of human behaviour, leaving the field and then writing up their data--without giving the people under investigation anything in return. Due to this fact, coupled with the persistence of the gatekeepers, I felt an obligation to give the institution something in return; thus, I offered to give the institutional officials a copy of the resulting study as well as a presentation of my findings to the ward staff, in order that both parties would benefit from the research experience.
- 12 This action is an illustration of an institution's attempt to 'pass the buck.' Because the research project was incompatible with the interests of the institution, its representatives actively attempted to 'channel' my interests elsewhere.

- 13 For a discussion of this 'give and take' of exchange process, see: Johnson (1975).
- 14 See Haas and Shaffir (1980:244-255) for a similar discussion.
- 15 Every time I went to do fieldwork on the ward, I was forced to explain my identity to each of the staff members. The ward staff operated on a rotation basis whereby each month they were transferred to another ward; thus, each time I arrived, I was confronted with an entirely different set of 'ward gatekeepers' who were unaware of my identity and the aims of the study. As a result, I was forced to spend time explaining who I was and the objectives of the research to these staff members--actions which threatened to destroy the trust of the patients that I had worked so hard to establish. Specifically, my interaction with the staff was interpreted by the patients as being traitorous and it was only through perseverance that I was able to regain my informants' trust.
- 16 For a discussion on the subject of 'going native' or 'over-rapport,' see: Spradley and McCurdy (1975:60); and Miller (1952:97-99).
- 17 See Bruyn (1966); and Schwartz and Schwartz (1955:343-354).
- 18 For a discussion regarding similar problems of gaining access, see the following: Barber (1973:103-112); Habenstein (ed.) (1970); Haas and Shaffir (1978); West (1980); Hoffman (1980).
- 19 As the reader can see, access was obtained into the second institution much more smoothly and expediently. The reasons for this relatively easy access were two-fold: (1) in the second institution, I was 'sponsored' by a member of the psychiatric profession rather than attempting to 'sell' the study on my own; (2) the psychiatrist at the second institution was more sympathetic to a sociological approach to the study of mental patients, for he himself was actively involved in psychiatric research that included social psychological and sociological factors in the analysis. In contrast,

the psychiatrists at the first institution advocated a strict traditional approach to the study of psychiatry and psychiatric patients--a stance that was antithetical to my sociological study. For this reason, coupled with the former, I had much more difficulty in obtaining access and maintaining relations in the first research setting in comparison to the second setting.

- 20 See Blanche Geer (1967:372-398) for a detailed description of a researcher's first days in the field.
- 21 See Shaffir et al. (eds.) (1980:111-116) for a discussion of this subject.
- 22 This term has been employed by Becker et al. (1961); Gans (1962); Whyte (1955) and Glaser and Strauss (1967).
- 23 Coupled with the fear of rejection, researchers are also often afraid that their subjects may cause them physical harm. In my case however, I never felt afraid of the patients I studied. I rejected popular stereotypes of mental patients as being individuals who 'don't know what they are doing,' and who are 'extremely dangerous.' My father was employed at a psychiatric institution for a number of years during which time I frequently interacted with patients--interactions which dispelled any popular conceptions I may have previously had of mental patients.
- 24 See Sanders (1980:160); and Bogdan and Taylor (1975:42-43).
- 25 See for example: Douglas (1976)..
- 26 Such researchers as Erikson (1965); Gold (1958:221-222); and Davis (1961) oppose conducting covert research.
- 27 See Rosenhan (1973:250-258); and Goldman et al. (1970:427-434).

28. See Goffman (1961:ix).

29 I felt an ethical obligation to answer patient questions posed to me in the course of my interviewing. I felt that it was not fair of me to ask questions of them (many of which were personal in nature) and then refuse to answer questions they had of me.

CHAPTER FIVE

THE PRE-PATIENT PHASE IN THE CAREER OF THE MENTAL PATIENT

This chapter, based on my data analysis of eighteen subjects introduces the first stage in the career of the mental patient--the pre-patient phase.¹ Specifically, it examines the social conditions which may lead to hospitalization in a psychiatric facility. Conceiving of mental illness as subjectively problematic, this discussion will focus on:

(1) the social conditions upon which an individual is adjudged to be 'mentally ill' and is segregated from the community--the social audience who react to certain types of rule violations and redefine the individual as mentally ill;

(2) the types of rule violations against which the audience react and take action;

(3) the reaction of the individual adjudged to be mentally ill--his/her social experiences prior to hospitalization.

Pathways Leading to the Mental Hospital

Mental illness, according to the social-role model is not an inherent feature that characterizes the mentally ill; rather, it is a social definition bestowed by members of society upon individuals exhibiting certain types of behaviour.

Seen from this perspective, the career of the mental patient begins when societal members react--express discontent and/or take action against behaviour exhibited by the actor and subsequently define him/her as 'mentally ill.'² Specifically, individuals are adjudged to be mentally ill when they exhibit a special type of culturally-inappropriate behaviour--behaviour to which Scheff (1966:33) refers as 'residual rule violations:'

The culture of the group provides a vocabulary of terms for categorizing many norm violations: crime, perversion, drunkenness and bad manners...Each of these terms is derived from the type of behaviour involved. After exhausting these categories, however, there is always a residue of the most diverse kinds of violations for which the culture applies no explicit label... Although there is great cultural variation in what is defined as decent or real, each culture tends to reify its definition of decency or reality, and so provides no way of handling violations of its expectations in these areas. The typical norm governing decency or reality, therefore, literally 'goes without saying' and its violation is unthinkable for most of its members. For the convenience of the society in construing those instances of unnamable rule-breaking which are called to its attention, these violations may be lumped together into a residual category: witchcraft, spirit possession, or, in our own society, mental illness.

{ Mental illness then, according to this perspective is conceived as a residual category of deviant behaviour--violations for which society provides

no explicit label.

In my study, the majority of the subjects began their careers as mental patients when members of society reacted to such residual rule violations as: (a) throwing dishes at a family member, (b) breaking a window in the house, (c) repeated urinating and defecating oneself, (d) refusal to maintain habits of cleanliness, (e) providing unacceptable responses to others in the context of social interaction, etc.

A large proportion of residual rule violations frequently go undetected--the behaviour remains unrecognized, or if it is acknowledged, it is rationalized or 'normalized' by the social audience.³ While various residual rule violations are ignored or rationalized away, in some instances, individuals exhibiting similar violations are reacted to by societal members and are labelled as mentally ill. Goffman (1961:134), taking as problematic the application of the label 'mentally ill' states:

For every offense that leads to an effective complaint, there are many psychiatrically similar ones that never do. No action is taken which leads to other extrusory outcomes; or ineffective action is taken leading to a mere pacifying or putting off of the person who complains.

In other words, defining an individual as mentally ill is not an automatic process. Whether a person is so labelled is contingent upon several factors, including the tolerance level of the community, the severity of the rule violation, and/or the social status of the rule breaker relative to the audience reacting to his behaviour (Scheff, 1975:10).⁴

A number of studies focussing on the tolerance limits of the family

have documented the capacity of family members to minimize, overlook, and rationalize evidence of mental illness.⁵ It is only in the event of a shift in the tolerance of the family members--when the individual's behaviour becomes unmanageable, when a crisis situation develops,⁶ that others define him/her as being in need of psychiatric help. The data from this study suggest that family members adopted similar patterns of accommodation--suspicions of mental illness were rationalized or normalized. Such accommodative mechanisms collapsed when family members were confronted with an unmanageable emergency. As the mother of a young woman, hospitalized for exhibiting 'bizarre' behaviour recalls:

My daughter wasn't quite 'right' for a long time. But it took me a long time to realize that. You see, at first I refused to face that anything was wrong with her. Her grades started getting worse when she entered high school. But I thought that she was just not trying hard enough. Then she started to get worse--I mean by being violent. Initially, I thought that she was just letting off steam--I didn't realize that she was 'sick.' But gradually I came to the conclusion that she was sick when one day she got so mad at me that she went 'beserk' and started throwing things. I was so afraid that I called the police. (Interview #47, January 28, 1981:1).

Not only do accommodative patterns break down in crisis situations, but also result when the individual repeatedly exhibits culturally-inappropriate responses in the context of social interaction with others. As Mechanic (1962:68) states:

Mental illness and other forms of deviancy become visible when persons in the participant's group recognize his inability and reluctance to make proper responses in his network of interpersonal relations.

Similar to Laing and Esterson (1964), in my study I found that individuals were adjudged by significant others to be mentally ill as a consequence of their inability to accurately respond to interpersonal demands of others in the situation.⁷ As one family member recalls:

I gradually realized that something was wrong. When I would ask Joe a question, he would answer in a strange way. I mean, if I asked him a question about 'apples' he would answer and tell me about 'oranges.' Our conversations just didn't click! That's when I realized that he must be sick (Interview #56, April 2, 1981:1).

Similarly, a friend of an individual hospitalized in a mental facility states:

Before she was hospitalized, it was just like she was on another wavelength. I would be talking about a certain thing and she would answer me with a statement that was completely alien to the conversation. Sometimes she didn't answer at all. At first, I just shrugged it off, but when it persisted, I realized that she must be mentally ill and desperately in need of psychiatric help (Interview #58, April 13, 1981:4).

A third individual, recalling his wife's behaviour prior to hospitalization states:

My wife started acting 'funny' a few years ago. I mean, she went into this depression and wouldn't talk to anyone. No matter what anyone said, she just wouldn't answer. Then, after a while when she did answer, she would say things that didn't make any sense whatsoever. That's when I decided to get her psychiatric help (Interview #57, April 8, 1981:2).

In short then, the career of the mental patient begins when societal members notice that the behaviour exhibited by the person is strange or peculiar. Although the social audience may initially deny or minimize the peculiarity, if the individual repeatedly fails to respond to the interpersonal demands of the other in the situation, or if his behaviour becomes unmanageable, societal members move toward defining him as mentally ill.

A number of agents and agencies participate in the definitional process and subsequent hospitalization of the individual. As Goffman (1961: 135) notes, these "circuit of agents--and agencies--participate faithfully in his passage from civilian to patient status." Essentially, in my study, four agents reacted to residual rule violations exhibited by individuals, thereby activating commitment proceedings into the mental hospital:

- (1) Self as agent;
- (2) The legal system as agent;
- (3) Family and Friends as agents;
- (4) Psychiatric Officials in a general hospital as agents.⁸

Self as Agent

One possible pathway leading to psychiatric hospitalization is through self-referral. A small number,⁹ upon self-examination find themselves to be acting in strange and incomprehensible manners. Such behaviour often frightens the person and leads him/her to believe that he/she is 'going nuts' or 'losing his mind.' This threatening view of self as being potentially mentally ill impels the individual to admit him/herself willingly to a psychiatric facility. One patient, discussing his experiences as a pre-patient states:

I kept hearing voices before I came to the hospital. I didn't know what was happening to me. It was so frightening. I thought that I was losing my mind--going bananas. That's when I decided to admit myself to the hospital and get help (Interview #19, January 2, 1980:5).

Similarly, another patient states:

It all started about four years ago--things happened to the family--my mother died; my two uncles died; my aunt died. I was very close to my aunt. My son and I used to live with my aunt in her house. I used to look after her. I saw that she was gradually going down hill and I knew that she was going to die. It was very hard on me. When she did die, I became very depressed...It was really depressing and my nerves got bad. To make things worse, my son decided that he would like to go out on his own. It was such a big shock and it depressed me further. I didn't want to eat or take care of myself. I knew that something was wrong with me. I wasn't 'normal.' That's when I decided to get help for my nervous breakdown and came to the hospital. (Interview #53, March 13, 1981:3).

Concomitant with the self-realization that he/she is in need of psychiatric help, the pre-patient is also faced with the sometimes arduous and anxiety-provoking task of attempting to conceal from others his/her newly discovered discreditable image of self. The individual struggles to maintain his/her role as a 'normal' person in the context of social interaction with others while constantly fearful that he/she will be 'found out.' When the social situation becomes too stressful for the pre-patient to manage, he/she often feels relief by admitting himself/herself into the mental institution. As Goffman (1961:132-133) notes, "instead of being himself a questionable person trying to maintain a role as a full one, he can become an officially questioned person known to himself to be not so questionable as that." A person, describing his stressful experiences prior to hospitalization states:

In my heart I knew that there was something mentally wrong with me, but I tried to hide it. I tried to hide it from myself but I eventually realized--I faced the fact that I needed help...I couldn't concentrate--I felt so mixed up-- I thought that everyone was against me. And these feelings got progressively worse as time went on. As well as trying to hide my illness from myself, I also tried to hide it from my friends and other employees at work. Sometimes, it was quite difficult to pretend everything was ok. I kept wondering if they thought I was 'going mental'--whether they knew or not. I tried to hide it for a time, but that created more pressures on me until I couldn't take it anymore...It was a relief to go to the hospital. I didn't have to hide it anymore. Now I could get some help for my sickness (Interview #47, January 27, 1981:5).

Another person, recalling her experiences as a pre-patient states:

Things started building up on me. At first, I thought that I was just overtired--that I was working myself too hard. But

it got worse--it was harder and harder to make decisions. The work started piling up. I couldn't cope. I finally realized that something must be wrong with me. I was 'sick.' I wondered if my friends could tell that I was sick. I tried to hide it from them for awhile, but then it got worse and I had to get psychiatric help (Interview #56, April 10, 1981:2).

A third individual, discussing his stressful experiences prior to hospitalization states:

Life was hell before I was admitted to the hospital. I was so depressed. I couldn't eat. I felt like everyone was against me. I used to cry a lot--sometimes I couldn't stop. And this scared me to death. I didn't know what was happening to me. I was becoming mentally sick little by little. During this time it was difficult to carry on a normal life, when you know that something's wrong with you. It got to the point where I couldn't carry on anymore and then I went and got myself signed into the hospital (Interview #56, April 10, 1981:4).

For these individuals who were either frightened by the strange behaviour they were exhibiting, or were no longer able to manage the stressful experiences of attempting to conceal certain discreditable aspects of their selves from others, admission to the psychiatric hospital is seen in a positive light.

Despite the fact that some pre-patients admit themselves willingly to the mental hospital for treatment, the majority of individuals are admitted by various agents and agencies against their will. For these individuals admitted involuntarily, their social experiences as pre-patients are generally seen in a negative manner (Goffman, 1961). Since the majority of persons in my study were admitted in this latter manner,¹⁰ this discussion will now focus on the various agents that participate in

committing the individual involuntarily and the individual's reaction to such action.

The Legal System as Agent

A number of individuals mark the beginning of their careers as mental patients when legal authorities interpret their behaviour as evidence of mental illness and consequently admit them to a psychiatric facility.¹¹ Specifically, legal authorities participate in the individual's passage from civilian to patient status in two ways:

(1) A person exhibiting 'bizarre' behaviour on the outside is apprehended by the police and admitted directly to a psychiatric hospital for treatment.

~~(2) An individual committing a legal offense is apprehended by the police and imprisoned. At a subsequent hearing, the court decides to send the person to a mental hospital for psychiatric evaluation.~~

In terms of the former path, some individuals, although not breaking the law are apprehended by the police. That is, according to a provision in the legal mandate, police officers are given the authority to apprehend and hospitalize individuals acting in a strange manner—persons committing residual rule violations. From the standpoint of the police officer, psychiatric hospitalization of the individual is conceived

as a necessary step in order to ensure that he does not injure himself/herself or others. However, from the point of view of the person himself/herself, his/her apprehension and involuntary hospitalization are events which he/she sees in a negative light. Specifically, most individuals apprehended and hospitalized by the police cannot comprehend why such action was taken against them. For these persons, hospitalization is unjust--they adamantly deny that anything is wrong with them. An individual, expressing the moral outrage of his social situation as a pre-patient states:

I just can't understand it. One minute I was out there minding my own business--not bothering anyone, then the next minute, I find myself being brought to the hospital by the cops. I never did anything. I'm not sick. There is no way that they should have done that to me! I demand to be let free! (Interview # 17, December 20, 1979: 15).

Similarly, another person states:

I was on a highway and the police just picked me up and brought me here. I never asked them why they picked me up. I was too scared. I can't understand why they brought me to this place. To this day, I still don't know why! (Interview #54, March 18, 1981:9-10).

A third individual, recalling his experiences with the police as a pre-patient states:

I wasn't doing nothing wrong when they (the police) picked me up and brought me to the hospital. I wasn't doing nothing I tell you. They had no reason. I wasn't breaking any laws.

I was just going about my own business, but they said that they thought I was confused. They were wrong. They had no right to imprison me like that (Interview #22, January 17, 1980:8).

In short, individuals I interviewed who were admitted to the psychiatric hospital by the police as a result of committing some residual rule violation felt that such action was totally unjust and demanded to be released immediately. These individuals felt that they were the victims of a gross misjudgment on the part of the police.

In contrast to individuals admitted to the psychiatric facility by the police as a consequence of exhibiting strange or incomprehensible behaviour, others are admitted by the legal authorities as a result of committing a legal offense. Persons breaking such laws as arson, burglary, murder, rape, etc., are apprehended by the police and taken into custody. During a subsequent court hearing, the details of the case are discussed; if the motive behind the crime appears to be irrational in the eyes of the judge and/or the defense attorney, the individual's sanity may be called into question. Hence, the court may decide to send the offender to a mental hospital for a psychiatric assessment in order to ascertain whether he/she is 'psychiatrically fit' to stand trial.¹²

The legal offender, wearing handcuffs is transported to the hospital by the police at which time he is handed over to the hospital staff and becomes the property of the psychiatric institution.

For such individuals, their moral experiences as pre-patients are generally conceived of in a negative manner. That is, most persons admitted to the hospital in this manner express indignation regarding the

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objectification of their selves by both legal authorities and hospital staff. One patient, recalling his social situation as a pre-patient states:

They treated me like an object, that's all! Right from the moment I was caught by the police, in the courtroom, right up until the time they handed me over to the ward staff of the hospital. No one talked to me like I was a person--they just talked about me as if I wasn't there. They treated me just like a piece of cargo that needed to be moved from one place to another (Interview #7, October 25, 1979:13).

Similarly, another patient recalls:

When I was brought up from the jail by the cops, everyone handled me like some piece of trash--something without feelings. They talked about me as if I wasn't capable of understanding what they were saying about me. It made me so mad (Interview # 9, October 31, 1979:15).

In contrast to persons admitted to the mental hospital by the police as a result of committing a residual rule violation--individuals who generally express moral outrage for such action taken against them, others committed via the court reacted to their incarcerations in a somewhat acquiescent manner. Although such pre-patients may not be in accordance with the adjudgment of their selves as potentially mentally ill, they are informed of the rationale behind the judgment, the course of the action that will be taken, and the length of time they will be required to remain in the hospital--knowledge which makes their social situations more tolerable. Conceiving of his situation as 'doing time', one patient states:

They (the court officials) don't know what they're talking about--trying to say that I'm crazy. I know that there's nothing wrong with me. Oh, I don't care what they think anyways. I'll just do my time. I only have to be here for thirty days for some kind of assessment, then I'll be out (Interview #9, October 31, 1979:17).

Another patient states:

There's nothing wrong with me. I'll be out of here pretty soon. I just have to be on my best behaviour and do my time and I'll soon be out. You just have to learn to bear it (Interview #9, October 31, 1979:18).

While some pre-patients processed by the court deny that they are mentally ill, others ¹⁴ however, prior to being sent for psychiatric examination, have come to see themselves as mentally unbalanced. For these individuals, admission (even involuntary admission) to a mental facility is often seen as a welcome relief to their problems. As one person explains:

I went to jail for break and entry. But you know, I never knew that I committed the crime until after it happened, and the police picked me up and told me what I did. I knew I needed psychiatric help...I didn't object to coming here (Interview #7, October 25, 1979:7).

For persons, who prior to hospitalization were already questioning their sanity, their entire experiences as pre-patients are generally conceived as a positive step toward the alleviation of their problems.

Family and Friends as Agents

A third group of agents who frequently play a role in the individual's passage from person to patient are his/her family and friends-- a group of persons with whom the pre-patient most frequently interacts, and in whom he/she places complete trust.

During the pre-patient phase of his/her moral career, the individual gradually discovers that although he/she has placed reliance on family and friends to be supportive in times of trouble, these are often the very individuals who are the first to doubt the pre-patient's sanity and take action against him/her. When the individual repeatedly fails to correctly respond to the interpersonal demands of the other in the situation, the others react to such behaviour and adjudge the individual to be mentally ill. Subsequent to interpreting the pre-patient's behaviour as evidence of mental illness, friends or family of the person, frequently enlist the help of the family physician, mental health official, justice of the peace, or other official third parties in committing the individual to the psychiatric facility--action which the pre-patient views as traitorous and conspiratorial in nature.

In some cases, the process of commitment begins when family members or friends attempt to persuade the individual into visiting a family physician or mental health counsellor for what they are repeatedly told is for 'consultation purposes only.' As one patient recalls:

My mother told me that nothing was going to happen to me. No one was going to take me anywhere. She said that the doctor just wanted to talk with me--we were

just going to talk--that's all! (Interview #20, January 5, 1980:8).

Similarly, another individual states:

My cousin came over and tried to talk me into seeing the doctor--just to 'talk things over.' She said that he would just talk about how I was doing and that would be the end of it (Interview #58, April 15, 1981:5).

If the individual refuses to oblige, he is often threatened by his significant others with desertion, legal action, or disfellowship. One person recalling his social experiences as a pre-patient states:

My wife told me if I wouldn't go to see the doctor then she was going to leave me. She said that she'd take the kids and get as far away from me as possible...(Interview #59, April 28, 1981:2).

Another patient recalls:

I was told that if I refused to keep the appointment with the family doctor, I would have to get out of my father's house and never show my face around there again (Interview #16, December 19, 1979:11).

A third individual states:

My husband threatened to take my two children and leave me. He said that either I go or he'd beat me up. So what choice did I have? (Interview #57, April 12, 1981:3).

Generally, a family member or friend, prior to attempting to persuade the pre-patient to 'consult' a professional, will have already set up the appointment. Moreover, he/she will have 'filled in' the official third party regarding the case history of the adjudged individual. Such action, according to Goffman (1961:137), "tends to establish the next-of-relation as the responsible person to whom pertinent findings can be divulged, while effectively establishing the other as the patient."

Prior to arriving for the appointment, friends or family members engage in polite small talk with the pre-patient--no mention is made of the pre-patient's impending fate. The pre-patient's significant others emphasize repeatedly that they will not let anything happen to him. However, during the course of the interview, the pre-patient gradually discovers that a coalition has been formed against him in an attempt to commit him to a psychiatric institution. That is, upon arrival for the appointment, the pre-patient finds out that he has been accorded the role of 'patient' by the professional and his significant others. Moreover, from the nature of the conversation and the types of questions asked during the consultation, the pre-patient realizes that he has been 'informed on' or betrayed. The pre-patient finds out that his significant others--those individuals who prior to the appointment stressed that they were 'on his side' and would not let anything happen to him, turn against him and take the side of the professional who emphasizes the need for hospitalization. In short, the pre-patient sadly finds out that his friends or relations, the ones on whom he thought he could depend, have betrayed him. A patient, discussing his feelings of embitterment and betrayal toward his family states:

All the time, they kept telling me that they weren't going to let anything happen to me. That's what they told me. They never mentioned one word about putting me in this hospital. Then we got to Dr. _____'s office and I saw what was really going on. My whole family and the doctor were plotting against me behind my back. My mother told the doctor all kinds of things about me even before I showed up. They were trying to get me committed to this place. They're all traitors and I hate them! (Interview #21, January 11, 1980:5).

Similarly, a second patient recalls:

My wife assured me that she would not commit me to this place. Even my own doctor promised not to let that happen. But boy was I ever a fool! Everything was set up by my wife and the doctor behind my back. It went so quickly that I was committed before I even realized what hit me. One minute they were my loyal friends, and the next minute they turned against me and put me in this hospital. I just can't forgive them for that! (Interview #58, April 15, 1981:9).

Psychiatric Officials of a General Hospital as Agents

A fourth and final route leading to hospitalization in a psychiatric facility is via psychiatric officials of a general hospital. Specifically, a number of individuals exhibiting symptoms of mental illness are reacted against by various social audiences and are admitted to the psychiatric ward of a general hospital for treatment.¹⁶ If a person fails to respond to treatment, or is diagnosed as being in need of extended psychiatric care, psychiatric officials subsequently transfer him/her to a mental hospital. Some individuals respond to such action taken against their selves in a positive manner:

When I didn't get any better after the shock treatments, they transferred me to Meadowdale. I didn't really mind going there. I thought that I might get treated better than in the ordinary hospital. I thought that they could help me to get better (Interview #53, March 13, 1981:4).

Similarly, another individual states:

At first in _____ (general hospital) they tried all kinds of drugs on me but it didn't make me feel much better. Dr. _____ thought that it would be best for me to go to the psychiatric hospital....I agreed because I wanted to feel better and get well (Interview # 56, April 10, 1981: 5).

Others, however respond to the action of transfer in a negative manner.

These individuals expressed fear and anxiety regarding their social fates:

I was scared, I mean, really scared when I found out that they were transferring me to this place. When I was on the psychiatric ward in the general hospital, I thought that they would just keep me there for a few days and then let me out, but I never thought I'd end up here. I didn't know how long they planned to keep me at this place and it scared me (Interview #45, January 21, 1981:5).

A second individual, discussing his feelings toward the action of transfer to a psychiatric institution states:

I was frightened to death when they told me where I was going to be sent. I didn't want to go there. I didn't know what to expect--I mean, what kind of patients were in there, what they were going to do to me. It really made me nervous (Interview #57, April 12, 1981:7).

While admission to a psychiatric ward of a general hospital against the pre-patient's will brings a loss of freedom, the action of transfer to the psychiatric facility proper represents yet a further loss:

It was bad enough in Oakridge (the general hospital). When they admitted me in there, they took away a lot of my things--they kept watching me all the time. I couldn't do anything freely on my own. But being sent here to Meadowdale was much worse. It was like becoming a lower being...You see, you lose most, if not all your freedom that you used to have when you come in. It's like going down a flight of stairs--you were once at the top, but when you get admitted, you quickly fall to the bottom (Interview #19, January 2, 1980:8).

Another person states:

It was worse once I got to Meadowdale. They took all my personals away...I couldn't even have my wallet and my money. You lose all your freedom. They lock you up like animals. On the outside you get to do pretty much as you want, but here you are locked in and controlled (Interview #19, January 2, 1980:6).

In general, most patients conceive of the pre-patient experience of transfer with animosity. While involuntary admission to the psychiatric ward of a general hospital is viewed by these individuals as a gross misjudgment, they conceive of the action of transfer as yet a further and more serious error on the part of others--a mistake that is unforgiveable. A patient, expressing contempt toward a psychiatric official's decision to transfer him to a mental hospital states:

I hate that doctor for sending me in here. How could he do this to me? He had no right. I feel like killing him.

I hated it when they admitted me to the psych. ward in the ordinary hospital--there was nothing wrong with me. They made a big mistake. But when that doctor said that I needed 'therapy' so he was sending me to Meadowdale, I nearly hit the roof. They were making a worse mistake--there was nothing wrong with me and they were sending me to the nut house. (Interview # 60, April 30, 1981:2).

In summary, this chapter has dealt with the pre-patient phase in the career of the mental patient with specific emphasis on the social conditions upon which an individual is defined as mentally ill--the reaction of the social audience to specific types of rule violations being the crucial definitional element. Secondly, this chapter focussed on the various social agents which participated in the definitional process and subsequent hospitalization of the adjudged individual, and the reaction of the person to such action taken against him/her self.

The next chapter will deal with the second stage in the career of the mental patient--the in-patient phase. Specifically, it will deal with the various admission procedures to which a person is subjected upon institutionalization, and how such procedures and regulations function to strip the individual of his/her present identity. Secondly, this chapter will discuss the hospital's privilege system as the chief context within which the patient is forced to adopt a redefinition of self as 'mentally ill.'

FOOTNOTES FOR CHAPTER FIVE

- 1 The reader should note that the pre-patient phase was not a central focus of this study; data collection focussed on the in-patient and ex-patient phases in the mental patient's career. This chapter then, based on my somewhat limited analysis of the pre-patient phase, presents a brief introduction to some of the social conditions which may lead to hospitalization, and the response of the individual to such action.
- 2 See Kitsuse (1965) for a discussion of the societal reaction component to the study of deviant behaviour in general.
- 3 This stage of rationalization is referred to as 'denial' by Cumming and Cumming (1957:92-103). See also, Clausen and Yarrow (1955:25-33) and Hollingshead and Redlich (1958:170-176).
- 4 For a discussion of some of the career contingencies that may affect hospitalization in a mental facility, see: Lemert (1946: 370-378); and Meyers and Schaffer (1954:307-310).
- 5 See, for example, Sampson et al. (1962); Yarrow et al. (1955); Schwartz (1957); Hollingshead and Redlich (1958); Laing and Esterson (1964).
- 6 Smith et al. (1963:228-233) in their research on the tolerance limits of the family found that accommodative patterns broke down when a 'last straw' type incident occurred.
- 7 See also Becker (1962:494-501); and Gough (1948:359-366) for a somewhat similar discussion regarding the definitional process of an individual as mentally ill.

- 8 For the purposes of this thesis, an analytical separation has been made between the four routes leading to hospitalization. However, in reality, there exists an interplay between the various agents' reactions to the residual rule violation and the individual--an interplay which is beyond the scope of this thesis.
- 9 In this case, five subjects (or 25% of the sample).
- 10 In this case, fifteen subjects (or 75% of the sample).
- 11 See also, Bittner (1967:278-292) for a discussion of police discretion in the apprehension of the mentally ill.
- 12 Psychiatric assessments ranged from 30-60 days during which time forensic staff evaluated patients by means of observation, interviews and psychological testing.
- 13 This theme continues, and is intensified during the in-patient phase of the person's career as a mental patient.
- 14 In my study, such individuals were in a minority, specifically only 5% of the sample.
- 15 The individual discovers that his family members are actually serving as 'double agents'--on the one hand they pretend to be loyal and supportive, and yet, such persons turn against the individual and realign themselves with the professional.
- 16 While some pre-patients are admitted directly to the psychiatric hospital for treatment, others are sent first to a psychiatric ward of a general hospital. The reason for such action is two-fold: (1) in some cases, individuals are living in a region

that does not contain a mental hospital; (2) with the trend toward deinstitutionalization of the mental health facilities, individuals are admitted to a psychiatric ward in a general hospital for short-term treatment and then are released back into the community. Only when such treatment fails are patients transferred for further treatment to a psychiatric institution.

CHAPTER SIX

THE IN-PATIENT PHASE IN THE CAREER OF THE MENTAL PATIENT

The Process of Admission: The Context Within Which Self is Mortified

As Goffman (1961:14) emphasizes in his study of total institutions,¹ the individual generally enters the institution with a positive conception of self; however upon admission and thereafter he is stripped of many of his accustomed possessions and symbols of identity including clothing. The individual is subjected to a set of mortifying experiences which function to strip him/her of his/her present identity. According to Goffman (1961:14):

The recruit comes to the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. In the accurate language of some of our oldest institutions, he begins a series of abasements, degradations, humiliations and profanations of self. His self is systematically, or often unintentionally mortified. He begins some radical shifts in his moral career, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and others.

In my study, I found that the patients were subjected to certain processes of mortification. Specifically, upon entrance the patient is

subjected to certain mortifying experiences or stripping processes that are elaborated in the form of 'admission procedures.' On entering the hospital, the individual is subjected to a systematic set of procedures: he is signed in, assigned to a specific nurse and psychiatrist, asked questions about his life history, certain possessions are taken from him and stored, he is given a physical examination, a haircut, instructed in the rules of the ward, assigned to a room, and is issued institutional clothing if he has none of his own. In other words, during admission procedures the individual is subjected to a variety of routine operations-- in essence, he is coded into an object that can be easily processed by administrative mechanisms of the institution.² While one might agree that these admission procedures are necessary for the efficient organization and operation of the institution, from the patients' point of view these procedures are seen in a different light. A new admission states:

When I came in here I felt so mixed up. I was scared. Two female police brought me up here; I had chains on my arms and my feet. They brought me up to the front door and handed me over to the hospital woman. I felt like a piece of garbage you know, not like a human being--they were treating me like a fucking object, that's all. So they handed me over to her and she took me to the ward. We entered the ward and I was signed in. Then they took me down to the sunporch and left me there alone. After about twenty minutes, they came in and got me, asked me a few questions and sent me back there alone again. This time they took me to a room where there was a doctor and a nurse. They were going to give me a physical examination. They told me to strip. I told them that I wasn't going to take my clothes off in front of a woman; she said that it was alright because she was a nurse. I told her to leave but she wouldn't. So I had to stand there nude, right in front of her--she just gawked at me. I felt like a piece of shit I tell you...the doctor examined me and I do mean all over...I felt so damned degraded...they do that a lot to us here (Interview #7, October 25, 1979:6).

Another patient, recounting his views on the admission procedures says:

(When you come in, they take away your possessions, but they also do something that's much worse--they take away your self-respect. You come in here thinking that you are basically a good, decent human being, but they somehow manage to degrade you--make you feel like an inferior, a nothing, a sub-human.) Let me tell you how it works: you come in here thinking you are a good person...But (from the first minute you come through the front door, things start to happen--they take everything away from you--your clothes, money. They strip you and examine you. Then they put you in pajamas... you feel degraded)..You feel like you are being pushed down a flight of stairs, each step of the way makes you feel worse. Some patients accept they are nothings, no good; others try to fight it for awhile, but in the end the staff finally get you where they want you--to admit that you are a nothing (Interview #28, February 6, 1980:11).

Upon admission then, the individual is subjected to a set of procedures which function to curtail or alter the self. The act of physical examination serves to strip the individual in two ways: not only does this procedure force the person to be physically stripped of his clothing, but also symbolically serves to strip him of his self-identity through degradation and humiliation. Moreover, during admission procedures and thereafter, the patient tends to be objectified by the staff. Whereas on the outside the individual is treated as a person and is given respect, upon hospitalization he is accorded an inferior status--he is reduced to the level of an object. In short, he is often treated as a non-person.³

The individual undergoes mortification of self in other respects as well. Upon admission the patient is stripped of many of his material possessions such as his wallet, money, identification, jewelry and other

valuables--items that are locked away in storage. Since in Western society material possessions are a significant part of an individual's conception of self, to be stripped of such items represents a major attack on the self. While the institution may rationalize this procedure in terms of protection of the patient's property, the patients however, tend to conceive of this situation in a different manner:

Don: You know what bugs me about this place?

Jane: What:

Don: They won't give me any of my 'personals'--you know, like my wallet, ID, and my razor and that kind of stuff...They have it but they just won't give it to me.

Jane: They did that to me, too. They took away all my jewelry and won't give it back to me. They want to see me beg for it and they still won't give it back.

Don: They make you feel like a piece of garbage--a nothing.
(When they take all our personals away, they take away who you are....)(Interview #8, October 28, 1979:13).

One set of an individual's personal possessions is related to self-conceptions in a special manner. On the outside, an individual possesses some control over the personal front which he presents to others. That is, he employs a variety of symbols and tools to create a desired image of self. He employs what Goffman (1961:21) refers to as an 'identity kit.' However, upon hospitalization the individual is stripped of his usual appearance as well as the equipment used to create and maintain it. In essence, he suffers a personal defacement. A new admission, dis-

cussing how his personal appearance was altered shortly after admission states:

The barber came on the ward last week and dragged me over for a haircut. I didn't want to get it cut off but they (the staff) made me...The barber just plunked me in the chair--didn't even talk to me and just cut off my hair....Shit, I felt awful you know...they were changing so much of me...Where was the old me? (Interview #7, October 25, 1979:17).

Another patient, complaining about the loss of some items of her identity kit says:

I hate it in here. They won't give me my razor so I can shave my legs. They even took away my manicure kit. I look like a mess now. I never looked like this before you know...If I want to shave my legs, I have to ask for the 'safety razor' at the nursing station (Interview #8, October 28, 1979:12).

The loss of certain material possessions and one's identity kit prevent the individual from presenting his usual image of self and represents another instance of how self is altered upon hospitalization.

After admission self-images and identities are assaulted in yet another way--specifically by means of a forced deference pattern. Upon hospitalization the patient soon learns that he must act politely toward the staff or else he will receive negative sanctioning. This very action of required deference functions to attack one's self-conceptions. The self is also mortified by virtue of the fact that the patient is forced to request permission (and is sometimes forced to beg) for small items and activities, such as cigarettes, going for a bath, spending one's own

money, going to the canteen, washing one's clothes--items and activities which the person was able to exercise on his own on the outside. This obligation not only places the patient in an inferior or submissive role, but also leaves him wide open for interruptions from the staff. On the outside if an individual desires something, his requests are readily granted; in contrast, upon institutionalization, his requests may often be denied, questioned or even ignored:

Last night, I waited and waited at the nursing station. I wanted someone to unlock the door so I could take a bath. The staff all saw me standing there but they just ignored me. After about ten minutes I yelled out to them and told them what I wanted but they just put me off. They told me to come back later and ask again (Interview #20, January 5, 1980:6).

Another patient describes the condescending treatment accorded the patients by the staff:

They treat us like children in here... 'Now if you're a good boy and ask politely, you can have one cigarette each hour' (mimicking the voice of a staff). Shit, if you smoke, how much is one cigarette an hour? But like I said, they treat us like kids; they talk down to us. It makes us feel 'un-human' if that is a word (Interview #7, October 5, 1979:9).

In sum, these demands for deference and the corresponding implications of inferiority present the individual with a self-image that is incompatible with his prior conception of self.

The self is also mortified in other respects. In Western society

there is no more important claim to status, prestige and identity than a person's job (Haas and Shaffir, 1978:33). As Everett Hughes (1958:314) states:

A man's work is one of the more important parts of his identity, of his self; indeed of his fate in the one life he has to live, for there is something almost as irrevocable about the choice of occupation as there is about the choice of mate.

A person's occupation is an intricate part of his self-identity. However, upon hospitalization the patient is separated from his occupation in the outside world; in its place, he is often given menial work to undertake for which he is paid a small sum of money. So for example, as part of the patient's 'therapy,' he may be obliged to help in the hospital kitchen clearing tables or scraping plates. For this labour he may be given a few cents or a cigarette. At the Industrial Therapy Workshop of the institution, patients are required to undertake light factory work such as filling packages and cartons with various goods. Others work at the hospital laundry where they wash and iron much of the institutional clothing. For this type of work, the patients are paid menial wages. Being forced to work at such tasks for small sums of money is degrading for the individual and represents yet another instance of how self is assaulted upon hospitalization:

Working at IT (Industrial Therapy) is ~~awful~~ awful. You start working for 20¢ an hour and you can work your way up to 70¢ an hour and that's doing heavy manual labour, like lifting crates. See that old lady over there? She makes

40¢ an hour stuffing kotex in a box. How degrading!...The money you make in here isn't enough to keep you in cigarettes. It's just token wages, that's all. I used to make over \$200.00 a week on the outside, but in here I'm lucky if I make \$10.00 a week...It's like a slap in the face, you know (Interview # 7, October 25, 1979:14).

Two patients, comparing hospital wages to wages in another institution state:

Joe: You know, it's better in prison than in here. In prison the pay is better. Some inmates make 5 or 6 bucks an hour for doing work.

Tom: Ya, when I was in jail I got paid \$1.90 an hour for working in the kitchen. But here in the mental hospital all they pay is 20¢ an hour. Ya, convicts are treated better than mental patients—even though we have to do shitty jobs in jail too, at least we're paid a bit better than in this joint! (Interview #12, November 16, 1979:8).

It is further important to note that another type of mortification occurs upon admission. Essentially, a type of contaminative exposure⁴ occurs upon entrance. While in the outside world an individual is able to segregate objects of self-feeling, such as his thoughts, actions and his physical being from certain contaminating items, in the hospital however, the boundaries of the self are violated (Goffman, 1961:23). Specifically, upon entering the hospital, a person's informational preserve relating to self is infringed upon. During entrance procedures information is collected regarding the patient's roles, statuses, and his past behaviours (including discreditable information) and is synthesized in the form of a case history of the patient. This file is made readily avail-

able to any staff member. The patient has virtually no control over who is allowed to learn certain discreditable facts about himself. In this sense, his territories of self are being violated. Because staff members have access to these case histories, sometimes in the course of group therapy sessions, the therapist forces the patient to reveal certain discreditable facts about himself in front of other group members. A patient recalling his experience in a group therapy session states:

I hate this place. They (the staff) know everything about us--especially all the bad things we've ever done. Every time I go to one of those sessions they keep bringing up my past. I know I've done a lot of wrong things in my life-- I admit to that, but they keep wanting me to talk about things I did a long time ago, right in front of the other patients. It makes me feel ashamed when I have to tell bad things about myself and they hear it. I don't want everyone else in the group to know all the things I've done (Interview #25, January 26, 1980:11).

Another patient says:

When you come in here the staff learn all about you, especially all the bad things you don't want them to know. It's all written down in black and white in your case history record that's kept at the nursing station. Before I came here, I could hide some of these bad facts about me from other people, but in here that's impossible (Interview #12, November 16, 1979:6).

While the patient undergoes mortification of self by contaminative exposure of the kind discussed above, he also undergoes mortification of self through interpersonal contamination. As Goffman (1961:28)

emphasizes, "when the agency of contamination is another human being, the inmate is in addition contaminated by forced interpersonal contact and, in consequence, a forced social relationship." Many times during a patient's hospitalization his physical being and room may be searched. While the institution rationalizes these actions in terms of the protection of the patients, nevertheless, this very action of searching, along with the person who conducts the search, functions to violate the boundaries of the self. A patient expresses this view:

You know what bugs me about here? They search our rooms for 'junk' (drugs) all the time...There's no privacy at all...Like today me friend Jack came in to visit me and when he left they called me to the office while the others (the staff) went into my room and searched through all my stuff. I saw them do it. Man, we got no privacy at all! (Interview #7, October 25, 1979:7).

Self is also assaulted in one final respect--through the enforcement of strict rules and regulations. On the outside, the individual has some control over his world--he is a free, autonomous being. As such, he is free to make choices on his own as well as to act as he pleases within certain prescribed limits. The correctness of his actions is judged only at certain times. The individual is accorded certain civil rights as a Canadian citizen. In contrast however, upon institutionalization, the mental patient is subjected to a rigorous set of rules and regulations that serve to control every aspect of the patient's life.⁵ The civil rights he once enjoyed on the outside are taken away from him. He no longer has free choice nor is he able to act as he pleases. The

patient's actions are constantly being judged by the staff, and negative sanctions result if he violates an institutional norm. A patient aptly describes this situation:

Did you know that mental patients have no rights?...When you come in here, you lose all the rights you had on the outside. There is no free choice in here--choices are made for you. Like you have to eat at a certain time, wash at a certain time when they tell you, work when they tell you. In here they force you to think and act the way they want...They're always watching what you do and if you goof up, you're punished...(Interview #21, January 11, 1980:3).

Another patient states:

When a person is committed into the mental hospital he loses most of the rights he had on the outside as a citizen. For example, we aren't allowed to vote anymore, drive a car or any of those things--we lose all those rights we used to take for granted. With no rights left, we are left to abide by the rules of the hospital or else receive punishments. Taking away all these things is like taking away part of your identity--you lose who you once were.⁶ (Interview #22, January 17, 1980:5).

In sum, the loss of certain rights combined with the vast body of rules and regulations to which the patient is subjected functions to threaten the individual's conception of self. No longer is he a self-deterministic entity; rather, the patient is reduced to a weak, helpless, dependent being.⁷

In summary, I have attempted to illustrate how a mental institution, in its effort to resocialize and rehabilitate its charges, begins by in-

initially stripping the individual of his old identity through various admission procedures. While the self is curtailed through these mortifying experiences, I would argue that it is largely within the context of the institution's privilege system that self is reconstituted.

It will be the purpose in the second part of this chapter to examine how self is reorganized in the framework of the privilege system. Specifically, I will undertake the following: (1) outline the major components of the privilege system; (2) its official purpose; and then (3) discuss its implications for self-images and identities.

The Privilege System: The Context Within Which Self is Reconstituted

Examination of the privilege system reveals that it is comprised of three basic components: formal norms, positive sanctions (rewards) and negative sanctions (punishments). In terms of the formal norms, it is evident that the mental institution possesses a rigorous and explicit set of rules and regulations detailing the main requirements of patient conduct. So for example, such rules prescribe at what time a patient gets up in the morning, what time he/she retires, when he/she is allowed to bathe, whether he/she is allowed to go to the canteen, attend social functions, etc.

A second major component of the privilege system may be termed positive sanctions or rewards. The mental hospital, in exchange for cooperation and compliance, offers the patient a small number of clearly-

defined privileges. As I pointed out earlier in this chapter, upon entrance the patient is stripped of many of his material possessions. Items and activities which the patient once took for granted on the outside, now become privileges upon hospitalization. Through the privilege system, certain possessions, items and activities are held up to the patient as possibilities which he can strive to regain. For example, when the patient becomes obedient in both thought and action, he might be given his identification and wallet back, allowed to go for a walk to the hospital canteen by himself, or even be allowed to venture into the city for a short time. In this sense, the individual feels that he is re-establishing some of the relationships with the outside world which were lost upon hospitalization.

A third and final component of the privilege system may be termed, negative sanctions or punishments. When a patient violates one of the institutional norms, he is punished. While corporal punishment is prohibited, punishments may take the form of being placed in the sideroom for a period of time, temporary loss of privileges, or even confinement to pajamas.

Two important points regarding the privilege system should be noted at this point. Firstly, discharge from the hospital is elaborated into the privilege system. As Denzin (1968:349-358) and Hollingshead and Redlich (1958) emphasize, certain patient behaviours and overall presentations of self serve to facilitate the acquisition of more privileges and ultimately, the patient's release, while other types of behaviour tend to lengthen his stay:

...if the patient presents himself in such a way as to communicate his acceptance of the 'psychiatric line,' the therapist

will act toward him in a way which defines him as a good patient and one who will be easy to treat...It would be predicted that patients defined as holding initial favorable attitudes toward the 'psychiatric line' would...remain in the hospital a shorter length of time (Denzin, 1968:350).⁸

Secondly, it is apparent that positive and negative sanctions of the privilege system become elaborated into a residential system. That is, certain places to sleep or interact become clearly-defined as places in which patients with certain privileges are allowed to frequent or abide. Basically, patients are moved back and forth from one spatial area to another within the ward as rewards or punishments for their behaviour and presentations of self. In this sense then, the system itself remains static while the patients are shifted back and forth within the structure. A patient explains how the privilege system operates:

When you first come in, you are often put in pajamas. You're not allowed to even wear clothes. You have no privileges at all....They put you on the back part of the ward; you can't go out to the other side of the ward--they have a locked door between the two sides of the ward. You're confined back here for a week or more (Interview #12, November 16, 1979:2).

Another patient recounts:

If you're good and behave like the staff want, you can work your way up and get more benefits....Like when you get semi-privileges you're allowed to go down to the other side of the ward into the music room and listen to the stereo. Also, you no longer have your room on the back part of the ward--the unprivileged side, but you get to move to a room on the front part of the ward with the more privileged people. Later you can work your way up to full-privileges which means that you

can go out on your own for walks or to the canteen (Interview #12, November 16, 1979:4).

At the official level, the privilege system can be seen to have two functions: (1) as a mechanism of social control; and (2) a therapeutic aim. That is, in terms of the former, the privilege system serves to make the patient obedient and cooperative in terms of the aims of the institution. The privilege system can be viewed as a mechanism of social control utilized to manage a large group of people. In terms of the latter function, the privilege system is also conceptualized by the institutional staff as having some therapeutic value. That is, this system functions to allow the patient to learn responsibility for his own actions as well as the actions of others. It serves to rehabilitate the patient so that he will be able to successfully return to the outside world. A staff member describing the purpose of the privilege system states:

The way I see the privilege system is this--it essentially has a therapeutic aim in that it provides the patient the opportunity to accept responsibility for himself and other patients...The privilege system also helps us control the patients...It provides the staff with information about a patient's behaviour that might otherwise be hidden, so we are able to judge him in this way...(Interview # 31, February 21, 1980:1).

Examination of the privilege system reveals that it is comprised of four levels. These are as follows:

Lowest Level	Level I	<u>WARD PRIVILEGES</u> --The patient is confined to the back half of the ward, often being forced to remain in pajamas.
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	Level II	<u>GROUNDS-ACCOMPANIED</u> --The patient has semi-privileges which means that he can move freely throughout the ward and is also permitted to go for a walk on the grounds if accompanied by a staff or a patient who possesses 'full-grounds.'
	Level III	FULL-GROUNDS--The patient has full privileges which means that he is allowed to go out of the hospital by himself, go to the canteen by himself, etc.
Highest Level	Level IV	OFF-GROUNDS--This level of the privilege system entitles the patient to leave the hospital grounds whenever he desires, providing that he returns within a specified time.

Essentially, when a patient enters the hospital, he is placed at Level I and is confined to the ward. After approximately one week's time,⁹ the patient can ask permission from the staff to attend a 'Privilege Meeting' which is comprised of two staff members and his fellow patients. At this meeting the patient asks permission to advance to the next level in the privilege system and be granted more privileges. The other patients then vote on whether the patient should be granted more privileges, and if a unanimous decision is reached, he is allowed to proceed to the next level. Although one might initially think that the privilege system operates in a democratic manner, closer examination reveals that this is not the case. Although the staff do not take part in the actual voting, they do however, possess the authority to veto any decision if they so

desire.

According to the ideology of the institution, the privilege system, the privilege system may be characterized as a resocializing and rehabilitating mechanism--a mechanism that helps the patient learn to 'accept responsibility' for his actions. As the patient gradually learns to be more responsible he moves from levels one through four and is eventually discharged back into society as a productive being. In contrast to the ideology of the institution however, when one attempts to make sociological sense of this system, it is seen in a different manner. Specifically, I would argue that the privilege system provides the chief context within which the patient is forced to adopt a redefinition of self as 'mentally ill' or 'deviant.'

From an interactionist perspective, one develops a self-identity on the basis of how he perceives others are perceiving him. One's self-conceptions reflect the image he believes others have of him and is closely tied to the reactions imputed to other individuals. Self, is socially-constructed and socially-maintained. When an individual initially enters a mental institution he possesses a conception of self that was made possible by the stable arrangements of society. However, upon admission and thereafter the patient finds that it is virtually impossible to manage his old identity. The patient is separated from individuals and structures on the outside which functioned to validate his behaviour. This social separation, combined with the various admission procedures serve to destroy or alter the individual's conception of self. Once stripped to a liminal entity, the hospital offers the patient an alternative identity of self as 'mental patient'--a self-image that is in-

compatible with his prior conception of self. I would argue that although the patient may not initially agree with this redefinition of self as being mentally ill, nevertheless, through the structure of the privilege system along with the shared definition of himself as being 'mentally ill' held by his significant others, the patient is ultimately forced to accept this redefinition. Blake and Moulton (1961:1-2) make the following statement regarding the processes of conformity, resistance to influence, and conversion to a new self-identity:

An individual requires a stable framework, including salient and firm reference points, in order to orient himself and to regulate his interactions with others. This framework consists of external and internal anchorages available to the individual whether he is aware of them or not. Within an acceptable framework he can resist giving or accepting information that is inconsistent with that framework or that requires him to relinquish it. In the absence of a stable framework he actively seeks to establish one through his own strivings by making use of significant and relevant information provided within the context of interaction. By controlling the amount and kind of information available for orientation, he can be led to embrace conforming attitudes which are entirely foreign to his earlier ways of thinking.

Further, Thomas Scheff (1966:57) in his discussion of role-playing writes:

Having an audience that acts toward the individual in a uniform way may lead the actor to play the expected role even if he is not particularly interested in doing so. The 'baby of the family' may come to find this role obnoxious, but the uniform pattern of cues and actions that confronts him in the family may lock in with his own vocabulary of responses so that it is inconvenient and difficult for him not to play the part expected of him. To

the degree that alternative roles are closed off, the proffered role may come to be the only way the individual can cope with the situation.

In my study, I found that new patients initially respond to their hospitalization by denying the there is anything wrong with them. They often assert a story proving that they are not mentally ill, that someone or something else is to blame for their hospitalization, and that the hospital officials are therefore unjust in forcing this new label upon them. The following quotations from patients provide illustrations of this self-respecting tendency:

10

I've gone through a lot of pain in my life. It's all those people out there who put me in here you know...Everyone on the outside is against me. I'm not sick but they say I am. It's just not true. They forced me to come in here (Interview #18, December 27, 1979:5).

Another patient states:

You know, I'm not crazy like the rest of them in here. I just got fed up with the working conditions in my home town. The town's dying. There's no decent jobs anymore. I came to the hospital to rest up, that's all. It's sort of a re-training programme for me (Interview #9, October 31, 1979:7).

A third patient states:

I went AWOL when I was fighting in Vietnam and they're still looking for me. That's why I'm in this place right now. I'm

hiding from them. There's nothing wrong with me (Interview #20, January 5, 1980:8).

While most of the time the other patients openly accept the patient's apologia without question, sometimes however, the patients force each other to view themselves as mentally ill. The following conversations aptly illustrate this point:

Bob: There's nothing wrong with me. I don't know why I'm locked up in here.

Dick: There's something wrong with you.

Bob: What?

Dick: You're sick—you're a dangerous mental, Bob. That's why you're in here. If you don't believe that, you'll never get out (Interview #21, January 11, 1980:4).

Similarly, two patients engaged in conversation state:

Mary: You're crazy Joan, you're retarded. Face the fact!

Joan: I am not.

Mary: Yes you are and you'll be in here for the rest of your life. (Interview #20, January 5, 1980:10).

While fellow patients sometimes play a role in forcing the individual to accept this redefinition of self as mentally ill, I found that it is

the staff, who through the context of the privilege system's rewards and punishments play a significant role in forcing the individual to adopt this redefinition of self.

Scheff (1966:84) in his study discovered that patients who found evidence for mental illness in both their past and present actions were rewarded by the staff:

Labeled deviants may be rewarded for playing the stereotyped deviant role. Ordinarily patients who display 'insight' are rewarded by psychiatrists and other personnel. That is, patients who manage to find evidence of 'their illness' in their past and present behavior, confirming the medical and societal diagnoses, receive more benefits.

In my study I also found that patients, through the context of the institution's privilege system were often rewarded for playing the role of the insane person. As a patient learns to play the role of 'being crazy', he is rewarded by the staff members by being allowed to advance to a higher level in the privilege system. A patient states:

The only way to get out of this place is to 'act crazy' and do exactly what the staff want. If you don't give in to the staff, you'll stay in here forever. Like I told you before, the staff all think we are completely insane--they tell us we are. If you disagree with what they say and argue that you're not, then you don't get anywhere. They get mad at you and make it tough. But if you go along with them and 'act' mental, then you'll be able to go places and maybe one day will be let out. (Interview #28, February 6, 1980:11).

Similarly, another patient states:

(The best thing I could do is to play along with whatever

the staff wants. If the staff think I'm crazy, I should act crazy and not make any trouble. That's the only way to get more privileges around here. That's the only way to ever get out of here.) If you don't, then you'll stay down at the bottom of the heap in here--you'll never move up in the privilege system or nothing (Interview #21, February 11, 1980:6).

The patient, in his desire to attain more privileges learns to play the role of 'mental patient' proffered by the staff.

Just as the patient is rewarded in the context of the privilege system for adopting this redefinition of self and its corresponding role, so too is he punished for refusing to do so:

If you deny you're mental and saying nothing is wrong with you, you get treated bad by the staff. They can make it tough. They say that you're misbehaving, so they keep you in pj's or put you in the sideroom (Interview #28, February 6, 1980:9).

Another patient states:

If you keep saying that you're not mentally insane, you'll get nowhere. The staff will think that you're really sick then. You keep saying nothing is wrong with you and the staff interpret that as defiance--they will say you are disobeying them and you'll get your privileges taken away. (Interview #22, January 17, 1980:9).

The patient finds himself in a difficult position. On the one hand, he does not want to accept this redefinition of self as 'mentally ill.'

However, due to the shared definitions held by his significant others, coupled with the rewards and punishments accorded him in the context of the privilege system the patient comes to 'play the role' of mental patient.

I would argue that this situation has serious implications for the patient's identity. Although the symptoms displayed by the patient may begin as a conscious pretense, the constant reinforcement from the staff ultimately causes these behaviours to become involuntary and habitual. In effect, role internalization occurs.¹¹

Cain (1964:278-289), in his study on 'borderline children' provides evidence in support of this view. That is, he found that institutionalized children 'learn' how to play at being crazy. These children possessed images of madness which were constructed from popular conceptions. Similar to my study, these children were also rewarded by the hospital staff for adopting 'crazy' symptoms. (And although the child may have initially, consciously played the role of being 'crazy,' through the repeated acting out of the role, combined with the reinforcements from the environment, he ultimately internalized this behaviour, and thus, it became an unconscious part of his behavioural pattern.)

In essence then, both Cain's study and this author's study indicate that the institution's perception of the individual produces a self-fulfilling prophecy whereby the patients come to be shaped in the image that the staff have of them. Just as a teacher's expectations in the classroom can produce brighter or duller students,¹² and the expectations of a researcher can produce his own reality,¹³ my study reveals that the

expectations of the institutional staff have similar effects.¹⁴

FOOTNOTES FOR CHAPTER SIX

- 1 A total institution may be defined as: "an institution... with encompassing tendencies... Their encompassing or total character is symbolized by the barrier to social intercourse with the outside that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, forests, or moors " (Goffman, 1961:4).
- 2 This is the case in most total institutions. See also, Sykes (1958:68); and Cohen (1953:19).
- 3 See also, Johnson and Dodds (1957) for a similar example.
- 4 This phrase was initially used by Goffman (1961) in his study of total institutions.
- 5 For a similar discussion of the prescriptions for behaviour in a mental hospital, see Smith and Thrasher (1968:316-324).
- 6 Mezer and Rheingold (1962:827-831) discuss the civil/legal implications of being admitted to a mental hospital. Once institutionalized, the patient loses a large number of his civil rights which he/she previously took for granted. Specifically, once hospitalized, the individual is not allowed to make a will, a deed or contract, cannot receive property, loses the right to vote, operate a motor vehicle, cannot get married or divorced, etc. Mezer and Rheingold emphasize that when an individual loses his civil rights, this loss is not selective—it is not assumed that his presumed 'illness' has affected certain areas of competency and not others. Because he has been adjudged as mentally ill, this definition strips him of all his civil rights despite his actual ability to carry out his rights in certain areas.

- 7 See Sykes (1958:73) for a similar discussion concerning the institutionalization of prisoners.
- 8 This theme will be fully discussed in the latter part of this chapter.
- 9 This time is variable depending on the particular patient involved.
- 10 This term was initially used by Goffman (1961).
- 11 For the patient who remains in hospital for a short period of time, role internalization may not occur, but if he/she is hospitalized for a long time or has been repeatedly institutionalized, the person ultimately internalizes this behaviour.
- 12 See Rosenthal and Jacobsen (1968:19-23).
- 13 See Orne (1962:776-783).
- 14 The in-patient phase in the career of the mental patient may be likened to the anthropological notion of 'rites of passage.' Essentially, this term refers to 'rites which accompany every change of place, state, social position and age' (Van Gennep, 1969:95). All rites of passage are comprised of three stages: (1) separation; (2) marginality or liminality; and (3) aggregation. During the first phase, symbolic behaviour functions to detach the individual from a fixed point in the social structure, from a set of cultural conditions or from both. That is, this symbolic behaviour, in the form of degradations and humiliations serve to strip the individual of his previous status. During the second phase, the liminal phase, the characteristics of the person are unclear. According to Turner (1969:95), "they are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention and cere-

monial."--individuals possess few if any of the attributes of their past identity. Moreover, they are often even stripped naked to symbolize that they have no status. Individuals are forced to humble themselves. They must obey their superiors implicitly. As Turner (1969:96) states: "it is as though the subjects are being reduced or ground down to a uniform condition to be fashioned anew..."

In the third phase, termed as aggregation or reintegration, the individual is reborn as a new being; he is now in a stable social arrangement once more. In short, the individual has been redefined as a clearly-defined structural type, and as such, is expected to behave in terms of this new definition. The reader can clearly see that the in-patient phase in the career of the mental patient has striking similarities with the notion of rites of passage--in symbolic terms, the patient is also stripped of his old status through sometimes degrading rites, he is reduced to a liminal being, then he is reborn with a new identity bestowed upon him by members of society and is obliged to act in accordance with this new status.

CHAPTER SEVEN

THE POST-PATIENT PHASE IN THE CAREER OF THE MENTAL PATIENT

As the previous chapter indicated, the individual enters the mental facility with a positive self-conception that was made possible by the stable arrangements of society. However, during admission procedures and thereafter, the patient discovers that it is virtually impossible to maintain his/her old identity. The in-patient is subjected to various admission procedures which function to destroy the person's conception of self. Once stripped to a liminal being, the institution offers an alternative identity of 'mental patient.' Although the in-patient may initially reject this label, through the constant reaffirmation of the institutional staff, combined with the structure of the privilege system, the patient is ultimately forced to adopt this redefinition of self--a generally permanent label and stigma that affects his/her further participation in society.

Once the mental patient is discharged from the hospital, there begins for him/her the task of rebuilding a more positive identity. The ex-patient attempts to forget his/her hospital experience; he/she desires to transform his/her deviant identity and begin life from where he/she left off prior to hospitalization. However, the post-patient quickly dis-

covers the difficulty of stopping a career in midpassage due to the numerous barriers and obstacles placed in front of him/her by society.

Generally, upon return to the community the ex-patient is confronted with unfavourable societal attitudes toward mental patients and mental illness in general. Due to the widespread negative social definition accorded mental patients, such individuals are persons with a stigma¹--a stigma which threatens their social status as 'normal' members of society. Mental illness then, is perceived by post-patients as an attribute that is deeply discreditable to their identities. For other stigmatized individuals whose 'differentness' or 'failing' is immediately apparent to others,² their task centres on the management of apprehension and tension in the context of social interaction with 'normals.' However, for most ex-mental patients, their differentness is not readily visible to others--thus, their task centres on the management of undisclosed discreditable information about their selves in order to control the stigma potential of mental illness, thereby enabling them to 'pass' as normal members of society.³

It will be the purpose of this chapter to deal with the post-patient phase in the mental patient's career with specific reference to:

(1) the perception of mental illness as stigma--how ex-patients define their condition as discreditable and objectionable; and

(2) the major strategies employed by ex-patients to manage such undisclosed discreditable information about their selves in order to mitigate the potential negative impact of mental illness on their daily round.

The Perception of Mental Illness as a Stigmatized Condition

Stigma, although having an objective basis in the 'real world,' can also be conceptualized as a subjective feeling that arises from a person's perception of self as possessing some discreditable attribute or condition. Some studies on stigma⁴ assert that the stigmatized ~~come~~ person comes to see his/her condition as discreditable as a result of interaction with others who react to his/her condition in a negative manner. However, as others note,⁵ the stigmatized not only learns the social meaning of his failing through direct exposure to 'normals' who reject him/her, but also through the person's acquired knowledge of cultural conceptions concerning 'people of his kind.' That is, by virtue of his participation as a member of society he is aware of the negative societal attitudes attributed to his condition. Despite the fact whether the individual learns the social meaning of his failing through negative experiences with others in the context of interaction, or through his acquired knowledge of public attitudes toward his attributes or condition, the stigmatized ultimately decides to control such discreditable aspects of his identity in order to avoid further or potential negative reaction.

Examination of the data reveals that ex-mental patients come to perceive their condition as discreditable through both processes. Specifically, in terms of the former, some post-patients learn the social meaning of their failing through interaction with others who ^{they} respond to the ex-patient's identify with a mixture of fear, rejection and disapproval:

People treated me differently once I got out of the hospital. They thought I was 'crazy.' They treated me so coldly. People I used to be good friends with now shunned me. They wanted nothing to do with me because I was in a mental hospital. (Interview #52, February 22, 1981:6).

Another discharged patient, discussing the fear of society toward ex-mental patients states:

No one really knows what it's like to be a mental patient--they're scared of us. When we get out, people act as though we were weired, dangerous, crazy beings...They run from us--afraid that we might do something to them (Interview #25, January 26, 1980:4).

Similarly, a third post-patient states:

When you're on the outside, it's like you have the 'mark of Cain.' When they find out you were a patient they treat you so meanly. They treat you like you were now, as a result of your hospitalization, somehow less of a person! (Interview #22, January 17, 1980:10).

For other ex-mental patients, they come to perceive their condition as discreditable through their awareness of societal conceptions (or misconceptions) regarding mental patients and mental illness. ⁶ One ex-patient discussing the lack of societal understanding of mental patients and the corresponding stereotypical image they have of such individuals states:

The reason I decided to hide the fact that I was in a mental hospital was not because I had negative experiences with people who knew I was a patient. But basically, I did so because of the public misunderstanding of people like us. Let me explain. You see, the problem with this world is that no one understands what mental illness is all about. They have this stereotype of mental patients as madmen, or lunatics. That's why the public is so scared and stay away from us as if we had the plague. (Interview #28, February 6, 1980:4).

A second post-patient supports the idea of societal stereotypes affecting their re-entry into society when he says:

Most of society is mixed up about what mental illness really is. They have all these wild ideas about the way we walk, talk and act. They mostly believe that we are going to do them some harm--That we're 'out of our minds.' They don't understand that mental illness is a sickness, like all the rest. There's no difference (Interview #50, February 14, 1981:5).

Another individual, contrasting the societal conception of mental illness with that of the physically disabled says:

No one understands us. We are regarded worse than cripples you know. Cripples get more sympathy from the public--we (mental patients) get nothing. They just think of us as 'insane beings' and stay as far away from us as possible. No one sympathizes with us. On TV, they have telethons for cripples--the public is educated about the disease and feels sorry for them and tries to help. But do you ever see a telethon being held for mental patients? No way! (Interview #31, February 22, 1980:10).

In sum, the post-mental patient, either through direct exposure

to rejection, awareness of negative cultural conceptions, or both, comes to perceive the social meaning attached to his failing as threats to his/her status as a normal member of society. As a result, the ex-patient attempts to construct various strategies in order to control such discreditable information about self.

Strategies of Information Management to Control the Stigma Potential of Mental Illness

I Dissociation/Avoidance of Others with the Same Stigma ✓

One of the major strategems of information management employed by ex-mental patients is to dissociate themselves and avoid contact with others of their own kind. That is, such individuals fear that interaction with other ex-mental patients might be observed by familiar 'normal' others, arousing these others' suspicions and leading them to discover the person's true identity. As a result, some post-patients attempt to avoid or limit such occurrences with other stigmatized individuals.⁷

One patient discussing this ploy states:

I was in this restaurant one day having a cup of coffee with an acquaintance of mine when all of a sudden I looked over to the booth next to me and saw a girl who I used to share my room with on the ward back in the hospital. I glanced over to her and she glanced back, but neither of us let on that we knew each other. Neither of us wanted the people we were with to find out the truth about us, so we acted as if we didn't know each other. (Interview # 52, February 22, 1981:7).⁸

While in some instances ex-patients can manage to avoid interaction with others of their own kind without extreme difficulty, other cases however, prove to be problematic. Some post-patients, upon discharge are able to return to their families; other however, for various reasons,⁹ are unable to do so and are placed by caseworkers into boarding homes, approved homes, and homes for special care¹⁰ --facilities specifically employed to house ex-mental patients. As a result of such placement, discharged patients are forced to interact with others of their own kind on a day-to-day basis--a situation which serves as a constant reminder of the individual's past experiences as a mental patient, thereby impeding the rebuilding of a more positive identity. One post-patient, discussing her social situation states:

I hate living in this boarding home. The thing I hate most is the other people in there--the other patients. Each time I see them it reminds me of my sickness, that I was in the hospital as a patient. In fact, the whole damned boarding house reminds me of this. I just want to leave this place and get on my own. That way, I would feel better about myself (Interview #52, February 22, 1981:4).

Similarly, another patient states:

It's not very good living in a boarding home. I'd like to move somewhere else. I wouldn't even mind if I went to an 'ordinary boarding home.' You know, a boarding home where I could live with a family and not with a whole bunch of patients from the hospital. I just want to forget the past but that's hard to do when you're living with fourteen other patients (Interview #53, March 13, 1981:5).

Not only does forced association with other stigmatized individuals pose an an obstacle for the ex-patient's reorganization of self but also serves to heighten his fear that others will discover his true identity. One post-patient, discussing this problem states:

I don't dare have my friends over to the boarding home. If they ever found out that I was living with other mental patients, I don't thin they'd react very positively. I tell them that I'm just renting a room somewhere. I'm just afraid that one day they'll come over and find out about me (Interview #53, March 13, 1981:3).

In response to this undesirable and anxiety-provoking situation, some ex-mental patients leave such facilities and find places to live on their own where they are better able to control such discreditable information about their selves. One discharged patient, in his desire to dissociate himself with other ex-mental patients and thereby mitigate the stigma potential of his failing, moved from a boarding home to the Salvation Army where he seeks to pass as a transient--an identity that is also discrediting, but one which he perceives to be the lesser of two social evils:

I live at the Salvation Army now. I've been there for over a year. I used to live in one of those boarding homes but I didn't like it much. They guys used to be getting into fights all the time--that's what happens when a bunch of patients live together. And you'd have to share your room with two other patients. It's much better at the Sally Ann--here you got your own room. If there are fights you can shut your door. But what I like best about it is that I get to associate with more 'normal' people here. You get transients and guys out of jail in here, but it's better than associating with

those patients in the boarding homes....Here at the Sally Ann, the other guys think that I'm 'one of them' and I don't tell them any different (Interview # 55, April 6, 1981:3).

Just as some post-patients attempt to avoid association with others of their own kind for the reasons mentioned above, so too do they avoid certain social settings, such as ex-mental patient clubs and patient drop-in centres for the same reasons. As one post-patient states:

I don't like to go to the Drop-In Centre. I'm afraid that one time, I'll be walking out the door and I'll bump into someone who doesn't know that I was in the mental hospital --someone who wouldn't be understanding. But it's not only that I'm afraid that someone will see me coming or going from the Centre and will treat me meanly, but it's also because of the people that I don't go there very often. You see, this place is for patients who used to be in the hospital--that's the kind of people that go there. I'd rather belong to other groups instead of this mental patient one. That's why I joined a group called 'Happy Haven'--a group of ladies who meet in the north end of the city once a week --they aren't mental patients, they're just normal people (Interview #53, March 13, 1981:2).

In short then, in an effort to control the stigma potential of their failing and achieve a more positive identity, some ex-mental patients avoid certain types of social settings and instead, frequent social groups comprised of 'normal' others.

II Selective Concealment as a Strategy of Information Management ✓

Another widely-employed strategy of information management adopted by post-mental patients is the technique of selective concealment of their discreditable aspects of self. Similar to Edgerton's (1967) study of the mentally retarded, my findings reveal that some post-patients, at certain times and in certain situations actively seek to conceal their failing; however, at other times and in other situations they freely disclose such information about their selves. Whether such individuals choose to conceal or disclose their discreditable features of self is contingent upon a number of variables including the ex-patient's perception of the stigma of mental illness, previous negative experiences with normal others, the type of social situation, and the post-patient's perception of how specific persons may react.

Examination of the data suggests that post-patients carefully segregate societal members in terms of those who can be trusted about their true identity and others who cannot.¹¹ In general, family members and longterm friends were considered by ex-patients to be 'trustworthy' and 'understanding.' One post-patient, discussing the rationale behind his disclosure to close friends and family members states:

I don't tell everyone about my being in a mental hospital. The average person doesn't respond to such news very positively. But I did tell certain people--some of my close friends and my family. My parents were wonderful and so were my friends. They stood by me all the way and supported me (Interview #55, April 6, 1981:4).

Similarly, another ex-patient states:

The people I told about my sickness and my admission to the mental hospital were my aunts and uncles and some of my friends who also had nervous breakdowns--I confided in them because I knew that they would know what I went through and be understanding (Interview #53, March 13, 1981:5).

While certain individuals are considered by ex-mental patients to be 'safe others'--people who 'won't respond negatively' to their failing, others however, are classified as 'risky others.' The ex-patient, as a result of previous negative reactions from certain normal others regarding his condition, or due to his perception that certain others may respond with rejection and disapproval, concludes that the best strategy is to conceal such information about self from such 'risky others', thereby mitigating the stigma potential of mental illness. As one ex-patient states:

I had one bad experience with my neighbour and from then on I decided to hide the fact that I had been in the mental hospital from the other neighbours. When I got out of the hospital and went back to live in my apartment, I confided in one of the neighbours--I thought I could trust her but I was wrong. She didn't understand about mental illness is and as a result, she didn't want to come over and talk with me, or even associate with me anymore. That's when I decided to keep my hospitalization a secret from the other neighbours (Interview #58, April 25, 1981:2).

Another patient discussing the reason behind her selective concealment from certain friends states:

I have some friends but I didn't tell them that I went to the hospital. The reason was that I didn't think that they would be sympathetic to my problems. You see, I didn't think that they really understood what mental illness is all about--they just had some stereotypic image of mental patients. If I told them that I was once a mental patient, they would have probably shunned me. That's why I decided to keep it a secret (Interview #52, February 22, 1981:2).

Just as some post-patients employ the strategy of concealment when in the presence of 'risky others', they also do so in certain 'risky situations.' Specifically, the case of employment¹² is conceived by some ex-mental patients to be one such high risk situation. These individuals, either through negative discriminatory experiences with employers, or due to the anticipated negative reaction of employers, conclude that the best strategy is to conceal such discreditable information about their selves in situations of employment. One ex-patient, discussing the discriminatory attitudes of employers toward ex-mental patients states:

After you've been in the hospital and go to apply for a job, like in the factory, and they find out that you were in a mental hospital, they won't hire you. They won't take the risk (Interview #50, February 14, 1981:5).

Another post-patient speaking from experience recalls:

When you go out and look for a job, the employer asks what you've been doing the past few years. What do we tell them? --that we've been in a mental institution for the last two years? If we tell them the truth, they'll never hire us. No one is willing to take a chance with us. That's what

happened to me when I went to apply for this job. I told the truth and the employer told me, "Don't call us, we'll call you.'....So you see, any way you look at it, ex-mental patients can't get decent jobs by telling the truth. Just like negroes or some other group, we're also discriminated against (Interview #28, February 6, 1980:4).

Ex-patients then, as a result of disclosing their identity to employers, find themselves being discriminated against. The only kinds of employments made available to such persons are low-paying menial tasks--degrading jobs which function as impediments to achieving a more positive identity. As one individual remarks:

(Before I went to the hospital, I was working at Massey-Fergusson for top money, but it's different when us patients get out. When patients get out they are forced to work for minimum wages, if that...I was offended at what they offered me when I finally graduated from that hospital. I was offered a job scraping the paint off old tool boxes, that's all. And the money wasn't very good. That's what's wrong with the system--once us patients get out of the hospital, we are forced to take degrading jobs. Don't get me wrong. I know that someone has to do the 'dirty' jobs too, and I'm willing to take my turn, but not all the time. It just isn't fair (Interview #55, April 6, 1981:2).

Thus, in order to combat such discrimination which limits their participation in normal social roles, specifically occupation roles, many ex-patients decide that the best strategy to employ is concealment of their true identity:

(The only way I can get a job is if I lie about my past history--don't tell them that I was a mental patient. That's the only way to get 'normal' decent jobs (Interview #27, February 6, 1980:4).

III Voluntary Disclosure as a Management Technique ✓

Just as some ex-mental patients attempt to mitigate the stigma potential of their failing by employing the strategy of selective concealment, others utilize the method of voluntary selective disclosure to achieve the same aim. Specifically, many post-patients often employ a type of disclosure referred to as 'preventive telling'¹³—a method of disclosure used to influence normal others' attitudes and/or behaviour toward self and ex-mental patients in general.

One type of preventive disclosure occurs in situations where the ex-patient anticipates that certain normal others will eventually find out about their discreditable identity and consequently reject him/her. Thus, in order to minimize the pain of subsequent rejection, such post-patient conclude that the best strategy to employ is preventive disclosure early in the relationship.¹⁴ As one ex-patient states:

I don't really like to tell people I was in the hospital, but if you don't and they find out about it later, they ask you why you kept such a thing a secret. As a result, they usually reject you—they don't want anything to do with you anymore. That's why it's better to tell these people at the beginning of a friendship and if they react negatively, well, it's less painful for you (Interview # 52, February 22, 1981:6).

Similarly, another individual states:

I've learned that it's best to tell some of your friends about it right away. That way if they freak out about it, at least you haven't wasted all that time in a false friendship (Interview #59, May 1, 1981:2).

A second form of preventive telling occurs in situations where the post-patient desires to enlighten normal others about mental patients and mental illness in general. That is, in reaction against popular stereotypic images of mental patients as 'dangerous, insane beings' who are something 'less than human,' the ex-patient attempts to inform others that mental illness is a medical problem--a condition that occurs 'beyond their control' and can 'affect virtually anyone.' In short, through the strategy of preventive disclosure, the post-mental patient hopes to influence normal others' attitudes and behaviour toward individuals of their kind, thereby mitigating the stigma potential of mental illness on their selves and daily round:

I decided to tell people about me being a mental patient basically because people out in society have so many misconceptions about us. This is the result of how we are portrayed on television--the media are the ones really responsible. I try to tell people I meet that mental illness is a sickness like all the rest. I tell them that one day it could happen to them too. It is something that is beyond their control--they can't help it. By telling them this, they can be more sympathetic, and won't keep their distance from me (Interview #50, February 14, 1981:7).

Similarly, another ex-patient states:

I tell people that I was in the mental hospital because I want to help others who are facing the same predicament as me. Society is misinformed about what mental illness is. They have these strange ideas about mental patients and as a result, they've come to be afraid of us or despise us. Either way you look at it, they definitely don't

like us. By telling people about what mental illness is, by teaching them, I hope that some of them will really begin to understand what it's all about and treat us more humanely as a result (Interview #55, April 6, 1981:4).

Summary

When the mental patient leaves the hospital and re-enters the community, his/her problems are far from being over. Although the ex-patient desires to abandon the negative self-image of mental patient and begin the restoration of a more positive identity, he/she finds out that certain barriers hinder such aspirations. That is, the ex-mental patient discovers that due to the widespread negative public attitudes toward mental patients and mental illness in general, individuals of his/her kind possess a stigma, a stigma which impedes the rebuilding of a more positive identity, and also limits his/her participation in normal social roles.

In response to this undesirable social situation, many post-patients construct various strategies of information management such as those discussed above--ploys designed to mitigate the negative impact of their failing on their selves and on their daily round.

FOOTNOTES FOR CHAPTER SEVEN

- 1 For a general discussion of stigma, see Goffman (1963). See also Ray (1961) for a discussion of the difficulties ex-addicts face in attempting to transform their addict identity.
- 2 For example, blindness or a facial deformity. For a detailed discussion of the management of discredited identities, see Davis (1961a:120-132); Barker et al. (1953); and Wright (1960).
- 3 In contrast to certain labelling theorists, most notably Scheff (1966), who present a view of mental patients as powerless victims--passive individuals who readily accept this redefinition of self and its corresponding negative consequences limiting further participation in society, this thesis subscribes to the view that ex-mental patients are strategists who construct various ploys of information control--strategies which they hope will control the negative impact of having been a mental patient on their self-images and on their daily round. For a somewhat similar discussion of the strategies of information control used by the mentally retarded in order to 'pass' as normal societal members, see: Edgerton (1967).
- 4 See for example, Hunt (1966).
- 5 Becker (1963).
- 6 For a discussion of such negative societal conceptions, see: Cumming and Cumming (1956), (1957); Lamy (1966); Nunnally (1957); and Woodward (1951).

- 7 Most ex-patients interviewed limited such occurrences in the sense that they only met with others of their own kind in 'safe places'-- locations where they felt that normal others would not observe them.
- 8 See also Greenwald's (1958) study of prostitutes for a similar example.
- 9 Such reasons include having no family to which to return, or that the family no longer wants the individual.
- 10 Approved homes, funded by regional government, are residential houses in which a family take in a few discharged patients to live with them. Homes for Special Care, funding by the provincial and federal governments, are facilities (sometimes residential homes or nursing homes) designed to care for post-mental patients as well as other individuals. Boarding homes, funded by regional government, are homes designed to care specifically for ex-mental patients.
- 11 See also Goffman (1963) and Schneider and Conrad (1980) for parallel examples.
- 12 See Miller and Dawson's (1966) study on the effects of stigma on the re-employment of ex-mental patients.
- 13 This term was drawn from Schneider and Conrad's (1980) study of epileptics.
- 14 Schneider and Conrad (1980) found that epileptics also employ this strategy of preventive telling in similar situations for similar ends.

CHAPTER EIGHT

SUMMARY AND CONCLUSIONS

This chapter is concerned with an overview of the career of the mental patient based on the analysis in the preceding chapters. Included in this chapter are the conclusions, limitations of the study, implications, and suggestions for future research.

This thesis has presented an updated study of the social world of the mental patient as he/she subjectively experiences it within a Canadian psychiatric setting. Advocating a symbolic interactionist perspective, specifically a social-role or labelling approach to the study of mental illness, emphasis was placed on the social processes by which an individual is segregated, labelled, and subsequently treated as mentally ill. Moreover, this study has also focussed on the individual's reactions to such labelling, the extent to which he/she adopted this re-definition of self as mentally ill, and the consequences of this new identity on the person's future participation in society.

As the data suggested (and is supported by other research),¹ the career of the mental patient began when societal members reacted to evidence of culturally-inappropriate behaviour or residual rule violations exhibited by the actor and subsequently defined him/her as mentally ill.

Although the social audience may have initially denied or rationalized the peculiar behaviour, if the actor repeatedly failed to correctly respond to the interpersonal demands of the other in the situation, or if the actor's behaviour became unmanageable, societal members moved toward defining him/her as mentally ill.

As the study indicated, a number of agents and agencies participated in the definitional process and subsequent hospitalization of the individual. One such possible agent was the individual himself/herself. Of the subjects interviewed, a small number, upon self-examination discovered themselves to be acting in a strange and incomprehensible manner---behaviour which was frightening and led such persons to believe that they were losing their minds. Such a view of self as being potentially mentally ill impelled these individuals to seek psychiatric help.

While some individuals referred themselves to the hospital upon the self-realization that they were in need of psychiatric help, others, for a time, attempted to conceal their newly discovered discreditable image of self. Such persons struggled to maintain their roles as 'normal' individuals in the context of social interaction with others while constantly afraid that they will be 'found out.' It was only when the social situation became too stressful that these individuals decided to admit themselves into the psychiatric institution.

A second agent who frequently played a role in the individual's passage from person to patient was the legal system. As the data indicated, a number of individuals marked the beginning of their careers as mental patients when legal authorities interpreted their actions as evi-

dence of mental illness and consequently admitted them to a mental hospital. Specifically, legal authorities, upon observing individuals exhibiting strange behaviour--committing residual rule violations, apprehended and admitted such persons directly to the psychiatric hospital for treatment. While the legal authority conceived of hospitalization as a necessary step in order to ensure that the person would not cause injury to himself/herself or to others, the individual conceived of his/her apprehension and involuntary hospitalization in a negative manner. For persons who were admitted to the psychiatric hospital by the police as a result of committing some residual rule violation, such action was felt to be totally unjust. As the data suggested, such individuals generally felt that nothing was mentally wrong with them; neither had they committed any legal offense. Therefore, according to their logic, such individuals were the victims of a gross misjudgment on the part of the police.

While individuals, admitted to the psychiatric facility by the police as a result of exhibiting strange or incomprehensible behaviour, expressed the moral outrage of their social situations, others, admitted by the court as a consequence of committing some legal offense, conceived of their situations in a somewhat different manner. The data indicated that although such pre-patients were not in accordance with the adjudgment of their selves as potentially mentally ill, they were informed by court officials of the rationale behind the judgment, the course of action that would be taken, and the length of time required to stay in the hospital--information which made their social situations more bearable.

A third group of agents who often played a role in the hospitalization of the individual were his/her family and friends. As the study indicated, during the pre-patient phase of the individual's career, he/she gradually discovered that the significant others on whom he/she relied to be supportive in times of trouble, were the very persons to first question the person's sanity and initiate commitment proceedings. Subsequent to interpreting the pre-patient's behaviour as evidence of mental illness, friends or family members enlisted the aid of certain official third parties such as the family physician, mental health officials, justice of the peace, etc., in committing the individual to the psychiatric facility. Such action was generally viewed by the pre-patient as traitorous and conspiratorial in nature.

A fourth group of agents who sometimes played a role in the individual's passage from person to patient were psychiatric officials of a general hospital. Some individuals interviewed, upon exhibiting symptoms of mental illness were reacted to by various societal members and were admitted to the psychiatric ward of a general hospital for treatment. When such individuals failed to respond to treatment, or were diagnosed as being in need of extended psychiatric care, they were subsequently transferred by psychiatric officials to the mental hospital for further treatment. While some individuals interviewed responded to such action in a positive manner, the majority responded to the action of transfer in a negative manner. In terms of the latter group, such individuals viewed this experience with fear and anxiety. For such persons, the action of transfer represented a further loss of freedom.

A significant turn occurred during the in-patient phase of the person's career. As the data suggested, prior to arrival at the psychiatric institution, the individual possessed a positive self-conception made possible by the stable arrangements of society. However, upon admission and thereafter, the individual found that it was virtually impossible to maintain his old identity. Specifically, on entering the hospital, the in-patient is separated from the individuals and structures which validated his/her behaviour. Such a social separation functioned to destroy the person's conception of self. Moreover, the data suggested that self was also destroyed in yet another manner--specifically, through the various hospital admission procedures to which the person is subjected.

Once stripped to a liminal being, the institution offered the patient an alternative self-identity of 'mental patient'--a self-conception that was incompatible with his/her prior conception of self. As the data indicated, although the in-patient initially denied that he/she was mentally ill and thus rejected this redefinition of self, through the context of the privilege system's rewards and punishments, the in-patient was ultimately forced to adopt this new self-identity--an identity which affected his/her further participation in society.

Upon release from the psychiatric facility, the person entered the post-patient phase of his career--a phase generally characterized by stigmatization. As the study indicated, once discharged, the person sought to rebuild a more positive self-identity; however, numerous barriers posed as threats to achieving such a goal. Due to the pre-

vailing negative social definition accorded mental illness and mental patients, such individuals are persons with a stigma--a stigma which threatens their social status as 'normal' societal members. In order to mitigate the potential negative impact of mental illness on their self-identities, such post-patients employed various techniques of information management, ranging from selective concealment to voluntary disclosure, thereby enabling them to live their lives as 'normal' members of society.

As with most research, the present study does suffer from certain limitations. In order to gather data on the social life of the mental patient as he/she subjectively experienced it, strict statistical measurements or controls were not employed. It is the contention of the researcher that one cannot achieve a full understanding of certain phenomena by merely statistically examining the relationship between social facts or the causes of social phenomena. Understanding can only be achieved by focussing on the subjective states of the individuals themselves.²

A second methodological limitation centres on the retrospective nature of the research. With respect to the pre-patient phase of the mental patient's career, information was collected based on retrospective accounts of individuals' experiences as pre-patients rather than following persons firsthand as they moved through this first stage in their moral careers.³

A third and final limitation of this research focuses on its one-sided nature. Due to time constraints, the researcher was unable to con-

duct a holistic study of the social world of the mental patient.⁴ Some sociologists contend that by focussing solely on one group, to the exclusion of another, will undoubtedly lead to a biased and distorted presentation of the findings. In response to this charge, in accordance with Becker (1966:240), I would argue that one cannot avoid taking sides when conducting fieldwork. But taking sides does not necessarily mean that our findings will be distorted and therefore be rendered useless. By employing our theoretical and technical resources impartially, by paying attention to our feelings as we conduct the study, and by limiting our conclusions, researchers can produce valid and reliable findings.

Despite these limitations, the data reported here lead to some interesting conclusions and suggestions for future research. This study, to a certain extent, replicates some of the findings of previous studies on the career of the mental patient. Specifically, similar to Goffman's (1961) study, my data indicate that individuals, during the pre-patient phase of their moral careers, sometimes undergo experiences which they conceive as alienating and treacherous in nature. Moreover, this study supports previous research on the in-patient phase of the mental patient's career.⁵ Although patients are subjected to more 'humane' treatment than in the past, and are now forced to remain in hospital for shorter lengths of time, they are still subjected to various institutional procedures which function to strip the person of his former identity and force the person to adopt this new identity of mental patient.

While this research replicates some of the findings of previous investigations, it also adds to our knowledge concerning the consequences

of institutionalization on the identities of mental patients. Whereas previous studies⁶ have generally portrayed ex-mental patients as powerless individuals who readily accept this redefinition of self as mentally ill and its corresponding negative consequences limiting his/her further participation in society, the findings of this present study suggest that ex-mental patients are more accurately conceptualized as strategists who actively construct various tactics of information control in order to mitigate the stigma potential of mental illness on their daily round.

The implications of this research are two-fold. First, from an analysis of the data one is led to conclude that mental institutions, in their present form, should be abolished. As Townsend (1978) and others have stated, mental hospitals like prisons and other institutions are counterproductive in the sense that they perpetuate exactly what they profess to erase. Lambo (1964), a Nigerian psychiatrist supporting the deinstitutionalization of mental health services from institutional to community-based care, has suggested that, in place of hospitalization, individuals with acute emotional problems would visit 'therapeutic communities'--communities that are not separated from society. Family members would accompany the person to the therapeutic community and would be actively involved in the treatment of the individual. For others, who have transitory behavioural problems, or were improperly socialized, Lambo (1964) suggests the construction of half-way houses, community clinics and day-care facilities.

A second implication of this research centres on the powerful and deleterious effect of staff expectations on the identities of hos-

pitalized persons. As the research suggested, although the symptoms displayed by the patient began as a conscious pretense in order to gain more privileges, through the constant reinforcement of the staff, the patient ultimately internalized such behaviours. In short, the institutional staff's perception of the patient produced a self-fulfilling prophecy whereby he/she came to be shaped in the image that the staff had of him/her.

While the present study was descriptive and exploratory in nature, it has provided insight into our understanding of the processes and consequences of institutionalization upon the self-images and identities of mental patients. In terms of future research, further attention needs to be given to specific aspects in the three phases of the career of the mental patient.

One such area of concern that needs further investigation centres on the role played by the pre-patient in the decision to hospitalize himself/herself. Although researchers in the area of medical sociology have discovered the differential willingness of certain social classes to define themselves as ill, few such studies have been conducted with reference to mental illness.⁷ While the present study has touched upon this issue, further systematic examination is needed.

On a methodological level, the majority of studies (including the present one), with respect to the pre-patient phase in the patient's career, have been descriptive and/or retrospective in nature. Thus, the data collected may have been subject to distortion and/or forgetting by the patient. Future investigations should be longitudinal in nature-- such studies should be designed and executed in a manner which would

follow the individual from the period prior to committing a residual rule violation until the time he/she is admitted into the psychiatric facility.

With respect to the post-patient phase of the mental patient's career, future research should focus on the effect different types of hospitalization have on the self-images and behaviour of post-mental patients. With the one recent exception of Howard et al. (1980), few attempts have been made to examine the effects of such differences.

Another area of potential research centres on the reaction of family members to the post-patient. With the exception of Freeman and Simmon's (1963) study, the majority of research in this area has merely focussed on such variables as differences in family type and social class factors to the exclusion of the interaction between family members and the post-patient himself/herself.

In order to gain a holistic understanding of the moral career of the mental patient, it would be useful for future research to empirically compare how different cultures' theories or conceptions of mental illness affect the symptomatology and course of the illness. While societal conceptions of mental illness have been compared between non-Western and Western societies,⁸ little attention has been placed on comparing cultural conceptions of insanity between Western societies.⁹

Despite the need for more research, the present study has provided a contribution to our understanding of the processes and consequences of institutionalization on the self-images and identities of mental patients and toward the formulation of a comprehensive sociological

theory of mental illness in general.

FOOTNOTES FOR CHAPTER EIGHT

- 1 See Scheff (1966); Laing and Esterson (1964); and Mechanic (1962).
- 2 This is not to say that qualitative research represents an end in itself. The present study merely represents an initial analysis from which hypotheses can be constructed and subsequently tested at a later time.
- 3 Although it would have been ideal to follow pre-patients first-hand as they moved through the first stage of their careers, such an aim was difficult to achieve. Due to the numerous problems encountered in attempting to make a bargain with the psychiatric institution, combined with certain time constraints to complete the research, I was forced to rely on retrospective accounts of individuals' experiences as pre-patients.
- 4 Although the researcher desired to study the situation from the point of view of the institutional staff as well, given the length of time to conduct this research, such an aim was impossible to achieve. Thus, the researcher decided to focus on one side--the side of the mental patient and present it faithfully.
- 5 Goffman (1961); Goldman et al. (1970); and Scheff (1966).
- 6 See for example, Scheff (1966).

- 7 See Mechanic and Volkart (1961) for a study which has centred on this problem in medical sociology.

- 8 See Fogelson (1965); Newman (1964); and Wallace (1972).

- 9 Townsend's (1978) recent study comparing cultural conceptions of mental illness in America and Germany is a notable exception.

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